

Rhode Island **MEDICAL JOURNAL**

JANUARY 1945



Meetings

66TH ANNUAL CONVENTION, R. I. State Dental Society

JANUARY 23 and 24

(See page 31 for details)

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MID-WINTER MEETING, R. I. Medical Society

FEBRUARY 5

(See page 21 for details)

Volume XXVIII, No. 1

Contents Page 7

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The RHODE ISLAND MEDICAL JOURNAL

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JANUARY, 1945

No. 1

WHAT OF THE DOCTOR-VETERAN?*

ALBERT H. JACKVONY, M.D.

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A YEAR AGO when we assembled here for our annual meeting we looked forward to the possibility of the end of World War II, at least the European phase of it, within the twelve month period ahead. Tonight we are assembled, this time to celebrate the 98th Annual Meeting of this illustrious medical Association, and again we are faced with the stern realities of a war that continues to struggle to a finish in Germany, and that narrows within closer confines in the Pacific theater.

The many and varied activities that have marked the work of this Association in peace times have given way to individual efforts in meeting the demands of war emergencies. I feel that we may be equally proud of the achievements of our doctors on the home front as of the heroic work of our colleagues who are serving directly with the armed forces. In the past three years the doctors at home, for the most part in the older age group, have given unstintingly of their time and energy to answer the call of the sick and to meet other requirements of the people. Their leisure, if any, has been generously allocated to such activities as civilian defense, Red Cross service, examination of selectees, and community welfare and health programs aimed at the extension of medical care.

As one of the most progressive and militant district medical societies in the country the Providence Medical Association has taken leadership in stimulating action in many important programs. To my immediate predecessor, Dr. Emery M. Porter, we are particularly indebted within the past year for his outstanding proposal made in his address before you last January wherein he drew the pattern for what has since become the first statewide voluntary health council in the coun-

*Presidential address delivered at the 98th Annual Meeting of the Providence Medical Association, at Providence, January 8, 1945.

try devoted entirely to the analyzing of health and medical problems. The adoption of that proposal by the House of Delegates of the Rhode Island Medical Society, and the subsequent activation of a Council by the Governor of the State are eloquent tributes to Dr. Porter's foresight and leadership.

I am sure that I speak for all of our members when I say that we are appreciative of the keen interest that has been shown by Governor J. Howard McGrath in the health problems of the people of our State, and we respect his confidence in the medical profession as the most competent group to develop any programs for the extension of medical services. This far-reaching proposal for compulsory hospitalization was referred by him to the newly-created State Voluntary Advisory Council on Health, and he has recommended that any plans for voluntary insurance programs to provide for pre-payment of the costs of surgical or medical care be developed under the auspices of the State Medical Society. We respect his confidence in the ability of organized medicine in Rhode Island to take constructive and progressive leadership in these matters. I know that confidence will be fully justified.

Through the columns of our newspapers and magazines, and by radio broadcasts, the public at large has learned of the glorious achievements of doctors of medicine on all the various war fronts in caring for the men of our armed forces. We, as doctors, are particularly proud of our colleagues, and I know that you recognize, as I have, the tremendous contribution these men have made and are making. In return they have looked to us to protect their interests at home, and we are endeavoring to meet that obligation.

Problems of Demobilized Doctor

There is another obligation, however, of which I wish to speak tonight. It is the issue posed by one of our doctors who wrote very recently that—"as one of the doctors in the Service, the problem that faces me is—what shall I do when the war is over? Must I start in from scratch again or

can I hope to find some system which will insure me an income for my services, especially during the first six to twelve months?"

The answer to that question is not easily given, nor can it be answered without bringing into the picture the entire resources of the medical profession of this State. Some may answer by saying that we can post the returning members in the *MEDICAL JOURNAL*, or even in the daily newspaper, or we may place them on our Committees commanding public attention. Others may well advance the suggestion that neighboring physicians be advised to inform promptly former patients concerning the returned medical officer, thus aiding him to restore his private practice. Or we may offer them services.

All of these gestures may well be adopted to the advantage of the demobilized physician. But there are other more serious aspects of the problem, as I see it. For example, we have no reason to believe that all our doctors will leave military service; certainly no great numbers will leave at any one time. And further, they will not be demobilized from Army service, if we understand the procedure correctly, on the basis of service, dependents or such factors, but purely on the basis of "need", thus paving the way for line officers to exert influence to retain the most efficient medical personnel as long as possible. If such should be the case there will be need for concerted action by the Association to seek the return of our outstanding colleagues as soon as possible for duty on the home front.

Again, consider the handicap for civilian practice that faces the doctor who completed an accelerated medical program, and a shortened internship designed to speed him into military service. We who have labored many years in the practice of the healing art know only too well that such hurried procedures violate all the established medical school and hospital teaching programs that have provided the firm foundation for the qualifications that have influenced the practice of medicine and surgery in this State for the betterment of all. The military medical care of men in the prime of life, as well as surgery by those physicians within the combat area, offer a far contrast to medical and surgical care for the civilian. The transition to private practice will not be an easy one for the military doctor, and we must seek ways to assist him both for his own good and for the maintenance of high medical standards in our communities.

The State Medical Society through its newly created Committee on University, Hospital and Medical Society Relations, has recognized the problem and is doing something about it. I urge every member of our Association to get solidly

behind this important committee which aims to provide the necessary post graduate educational programs and short term refresher courses for the returning doctors. Our men in the Services are being polled by this Committee, and their every request should be met by a united Profession at home. Only by our unselfish support of this type of program can the doctor returning from the war successfully transfer from military to civilian life.

Economic Phase Important

However, to provide the doctor returning from the war with educational programs to enable him to regain a scientific approach to civilian service is but part of the problem. We individually and as a group, must concern ourselves with the economic picture that faces the demobilized doctor. As I see it, this situation is a vital one, particularly as it affects the younger men who went directly to the Services from internships or residencies. Older doctors well-established in practice prior to their enlistment will need help to be sure, but I am confident that their experience and previous position in the community will materially lessen their difficulty in re-establishing private practice.

But how are we to help the young doctor who answered the call to military duty straight from a limited hospital training, and who will return to us with one, two, three, four, or more years of service with the armed forces for which he has received fixed compensation? Consider, too, the problem facing most of these doctors who have won promotions providing higher incomes, and who have married and established homes during this time. How can we best encourage him and help him to make the transition to competitive private practice without too great sacrifice for his immediate family?

We maintain that the best form of medicine in this country is that of private practice. Will we now come forward with strong evidence of our belief so that these young doctors will follow the paths we have trod and not be deterred into regimented programs under non-medical auspices? Will we recognize the seriousness of the problem that faces organized medicine in this post-war period? I am of the firm belief that we will.

The possible approaches to a solution of the problem are undoubtedly many. Certainly I do not feel qualified to present more than a few personal ones. I feel that doctors demobilized until now and probably those within the present year, will be readily absorbed into our communities with a minimum of difficulty. But for these men, and particularly for the larger group to follow them later, perhaps we may well explore the possibility of some system whereby older and more experienced doctors, individually or as a group, may take

continued on page 21

PUBLIC HEALTH ASPECTS OF RHEUMATIC FEVER*

JOHN R. PAUL, M.D.

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ONE should not attempt to discuss Public Health aspects of rheumatic fever without first considering its epidemiology. By epidemiology I really mean ecology, but regardless as to what term is best, each is used here to imply *the circumstances under which this disease appears*. Among these circumstances is the fact that rheumatic fever is a respiratory disease, — a contact disease, and a crowd disease. Beyond these our knowledge becomes sharply limited when we attempt to classify it on epidemiological grounds. Indeed there is some question as to whether we can speak of rheumatic fever as a specific disease at all, like tuberculosis or syphilis, instead of regarding it as a "rheumatic state", as suggested by the title of Coburn's book.¹ The question is raised because, from the standpoint of etiology, rheumatic fever is only one of a group of conditions known now as streptococcal disease, which means that that scourge, the Group A hemolytic streptococcus, is one of the responsible causative agents. But just how hemolytic streptococci actually cause rheumatic fever is still a mystery. We know of course that the association between throat infections (or tonsillitis) and rheumatic fever is an old one, in spite of the fact that it has never been really explained. From about 1885 until 1910, the usual view was that in some inexplicable way sore throats often preceded the rheumatism. From a later period (1910-30) this preceding attack of tonsillitis was described glibly as a *focus of infection*, — a catchword carrying the implication that the doctor could put his finger on the cause and the cure simultaneously. More modern and more illuminating observations in regard to this relationship began to appear in 1930, when it became apparent that after a latent period lasting from 3 to 18 days or more, a variety of late complications to hemolytic streptococcal infections might appear, of which rheumatic fever was only one. Such complications include cervical adenitis, nephritis, arthritis, and carditis. All of them are not the same, but it is believed that somewhere

within this complex pattern of late, usually non-suppurative manifestations of hemolytic streptococcal infections, the ultimate explanation of the pathogenesis of rheumatic fever will be found.

It is quite true that individual cases of rheumatic fever are often encountered in which no history of a preceeding streptococcal infection can be elicited. But the best evidence of a close relationship lies in the fact that although epidemics of streptococcal sore throat, tonsillitis, and scarlet fever are followed, *irregularly*, by groups of cases of rheumatic fever or even epidemics of rheumatic fever, the reverse is always true, namely *all epidemics* of rheumatic fever are preceded by epidemics of streptococcal disease. The experience of the last two years in both the Army and the Navy has served to strengthen this belief. Added to this is the fact that rheumatic fever can be prevented in certain carefully controlled clinic populations^{2,3} and in institutions for children⁴ by the daily administration of prophylactic doses of sulfanilamide or sulfadiazine. This has become clearer than ever through the work of Colonel Holbrook⁵ and Commander Coburn,⁶ in their studies on this subject in the military camps in this country. Final reports of the Army and Navy work are as yet not available. Until they are available it may be unwise to discuss this prophylactic measure in the light of civil practice. Nevertheless it is at present an important part of any anti-streptococcal campaign.

From the epidemiological standpoint we know therefore that these two diseases (streptococcal infections and rheumatic fever) go hand in hand. From the seasonal standpoint, the prevalence curves in New England at least, follow one another closely and it seems to be true here as elsewhere, that a "good" year for streptococcal diseases such as tonsillitis and scarlet fever, is a "good" year also for rheumatic fever.

So much for the close relationship between rheumatic fever and streptococcal infections in which it is granted that much is unknown. Until more is known some of us who have been interested in rheumatic fever as a clinical entity, believe that it would be a mistake to discard wholly the concept of rheumatic fever as a *disease per se*, any more than we should discard scarlet fever. How can one determine its prevalence for instance, unless

*An address presented at the Third Annual Meeting of the Children's Heart Association of Rhode Island, at Providence, December 13, 1944.

continued on next page

its individuality is upheld? This is important because local prevalence determinations are the corner stone of any Public Health program. From them we find that, although rheumatic fever is probably world-wide in distribution, it is enormously more common in certain areas than others, particularly areas in the temperate zones which are apt to have fairly long periods of inclement weather during which people tend to herd together within doors. The northern half of this country and the Rocky Mountain area represent rheumatic fever areas, within one of which New England and the Middle Atlantic States lie.

Determination of Local Prevalence

Nevertheless regardless of the area chosen, more vigorous steps should be taken to determine the local prevalence of rheumatic fever, for this disease has long been neglected from the standpoint of vital statistics. To begin with, the diagnosis is vague and as a result there is confusion in the existing data on its incidence, prevalence, and general importance. None of the methods used for these determinations is above criticism, but they are still the best methods at our disposal. From morbidity records we have found that in the Scandinavian countries, where rheumatic fever is a reportable disease, the incidence per annum has ranged from about 1 to 3 per 1,000 population.⁷ From *mortality* statistics, we find in this country, that juvenile deaths (age group of 5 to 24) from cardiac disease, which is one of Hedley's indices for rheumatic fever prevalence, have averaged 17 per 100,000 population.⁸ From *hospital-admission* figures — which are rough indices of the general importance of a given disease within a given community — we find that active cases of rheumatic fever make up from 0.1 to 5 per cent of the admissions to the medical services of general hospitals in this country.⁹ It is estimated that about twice this figure may apply to children's hospitals. From school surveys, we find that rheumatic heart disease has been detected among school children at the rate of from 0.3 to 4 per cent,¹⁰ and among college students from 0.6 to 1 per cent.¹¹ These figures indicate roughly the general frequency and importance of the disease in this country. In the northern half of the country it would seem to rank among the chronic infections, next to tuberculosis and syphilis in importance.

Rheumatic fever may be considered as a disease of childhood or school age because the age distribution indicates that the period of mid-childhood is the period of greatest vulnerability to first attacks. But the childhood aspects of the disease are not the whole story, for although first attacks of rheumatic fever occur most frequently during the 6 or 7 years preceding puberty, and although susceptibil-

ity both to first and recurrent attacks declines rapidly in the years after puberty, rheumatic fever is common enough during adolescence and young adult life, and medical problems which arise from both the active and inactive disease are equally common enough during the third and fourth decades of life. In young and mid adult life, rheumatic heart disease plays a more significant part than is usually suspected, for with the advent of early arteriosclerosis, an adequately functioning rheumatic heart may decompensate. Such a case is usually regarded clinically as a case of arteriosclerotic heart disease and the rheumatic element drops out of the picture, although actually it should not be left wholly to the pathologist to recognize the part which rheumatic lesions have played. As to racial susceptibility or resistance, there is uncertainty here because data on this point are generally unreliable; but Irish people living in the vicinity of New York City seem to acquire rheumatic fever somewhat more readily than do the average. Negroes do not seem to acquire the disease more readily than whites in this country, but their mortality rate from rheumatic fever is higher.

It is clear that living and home conditions, as well as climate and season, exert a profound influence, either directly or indirectly, on this disease. We are justified in designating rheumatic fever as a disease of late winter and early spring, and a disease of the slums. It is acquired at a higher rate in cities than in rural areas, and it is more prevalent among urban people who are subjected to the most crowding within their homes. Evidence from various sources tends to support the fact that the urban prevalence of rheumatic fever is higher in poverty-stricken areas than in areas occupied by the well-to-do. Damp crowded living quarters also seem to furnish opportunity for the spread of the disease, but this last observation has not been corroborated by all who have attempted to survey this aspect of the situation. And from this source comes the oft repeated story about "rheumatic streets and houses". If such foci of the disease exist, and we believe they do, it is here that the work on the control of air borne or contact diseases should be directed. The work of Army Commissions¹² in which much that is new has been learned regarding the spread of streptococci through sleeping and living quarters should eventually find application here in civil life.

Much has been learned about the epidemiology of rheumatic fever from the studies of *rheumatic families*, and there is evidence to suggest that the *tendency* to acquire rheumatic fever is inherited — a tendency which is not unlike that which seems to exist in tuberculosis. In a large family as many as three or four children may be found to have advanced rheumatic heart disease; and it is within

such homes, which are generally familiar to social workers in a Children's Cardiac Clinic, that Public Health measures should logically find their way.

All that has been said is the background on which Public Health measures can be based. These measures and programs have lagged behind other aspects of the study of this disease in most countries. Pioneer efforts have been made, however, over a period of 15 years, in London,¹³ and more recently in New York State,¹⁴ and in several States through the Children's Bureau.¹⁵ In the development of these programs emphasis has been placed, first, upon the necessary *education* which must be imparted to physicians, nurses, and medical social workers. High on the list is a plea for recognition of the fact that *basically* rheumatic fever stems from an infectious disease; second is a plea for better diagnosis; and third, the provision of care of those already suffering from the disease. There is no use in giving the public the idea that much is to be done about rheumatic fever without backing it up with therapeutic facilities. Here in this country we find far smaller provision for bed care, particularly long-term bed care, than is adequate to meet the needs of any good public health program.

This should include both medical and nursing care during both the acute and subacute stages of illness. The latter type of care requires special types of hospitals or homes, and it must be available to some patients for months, or even a year or more. During this period, protection from hemolytic streptococcal respiratory infection should be carefully considered. Provision for aftercare, or follow-up, during the inactive phase of the disease, is also essential.

Agency Co-ordination Necessary

Next as to where rheumatic fever belongs in the present medical or Public Health organizations. Cardiologists, led by the American Heart Association, have been active in fostering research in this disease and maintaining clinics and hospitals. Pediatricians have been equally active, with the various State Programs initiated by the Children's Bureau and controlled by the local Division of Maternal and Child Health. But both cardiologists and pediatricians will be among the first to agree that their interest covers but part of the picture. For success in the development of the program one must find an individual interested in the *disease itself*; interested particularly in its infectious aspect, and interested in the control of streptococcus infection by both old and new methods. This is one of the gaps to be filled in some areas. Many of the others have been filled in view of the fact that there is apparently no dearth of official and non-official agencies now ready and willing to take part in a rheumatic fever program. These agen-

cies include practicing physicians, university clinics, general hospitals, special hospitals, convalescent homes, local and State welfare societies, particularly crippled children's organizations, voluntary nursing organizations, groups interested in occupational and vocational therapy, medical social service, and local and State health departments; and last, but not least, the Federal Government through the Children's Bureau. In most places these agencies are working earnestly, but with some lack of coordination, and according to Rutstein,¹⁴ none of them individually is equipped to handle the entire problem. Coordination of these multifarious activities is obviously the major duty of a well-balanced public health program.

As to reporting cases which is often regarded as the first step in any program, it would not seem as if the time is yet ripe for making rheumatic fever a reportable disease with the expectation that the average physician will actually subscribe to this. The main stumbling blocks are that the average physician has yet to be shown that his patient, or the community will benefit by his reporting the disease, and furthermore, as there is still no specific test for the diagnosis of rheumatic fever, the problems of diagnosis are extremely difficult to both specialist and practitioner alike. But here is where the Cardiac Clinics come in, for they offer a valuable substitute for reporting. The proper listing of the cases within a given community, through the maintenance of a *rheumatic register* by a cardiac clinic, will greatly improve the vital statistics of this disease, within a given local area. The indications for improvement here are obvious, for, in keeping with the general importance of rheumatic fever, which, as we have said, occupies a place here among the chronic infectious diseases next to tuberculosis and syphilis, this disease should logically fall in line as the next for public health consideration.

In general summary, then, we find that rheumatic fever is not a rare and mysterious disease, but is common in the greater portion of this country and, epidemiologically speaking, it acts as a streptococcal infection. Many of its characteristics are similar to those of tuberculosis, but unlike tuberculosis, vital statistics are lacking, and it is only beginning to be regarded as a community problem. Public health programs have lagged accordingly. This situation should be changed when opportunities to do so are available.

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continued on page 20

HOW CAN WE AVOID THE RENAL COMPLICATIONS OF SULFADIAZINE THERAPY?*

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RECENTLY at the Rhode Island Hospital there were six patients at one time with various degrees of oliguria or anuria during or following sulfadiazine therapy. Two of these cases expired in anuria and were shown by Dr. B. Earl Clarke, pathologist, to have tubular necrosis due to sulfadiazine, and one had massive precipitation of acetyl sulfadiazine in the renal tubules. The other four recovered after stopping the drug and forcing fluids by the oral or intravenous routes. Many other instances, some fatal, have come to our attention and a review of complications of sulfadiazine therapy and how to avoid them seemed indicated.

Renal complications of a serious or fatal nature are to be feared when sulfadiazine is administered to a patient whose kidney function is already potentially reduced and to whom the drug is given without the adequate precautions which are fairly well known and which it is our intention to discuss. It seems to us certain that the widespread use of this type of medication in private practice without due consideration of the dangers involved must have resulted in many deaths in which the part played by the sulfonamide in the fatal outcome has not been recognized. Instances of such occurrences have come under the observation of all of us.

One important consideration in estimating the risk in using sulfadiazine is the age of the patient. In infancy and childhood the kidney is possessed of a vast excess of glomerulo-tubular systems, each a complete excretory organ in itself. As the years pass, these are gradually used up, many of them becoming sclerosed as a result of toxemias, interference with their blood supply or perhaps other causes, so that, as old age comes on, the kidney has little active excretory parenchyma to spare, although its total function may still be perfect as measured by the usual tests. Such a kidney can stand but little mechanical blockage of its tubules or necrosis of its tubular epithelium without serious loss of function. Thus it is proper to consider the age of the patient in gauging the risk involved in sulfadiazine therapy and the very fact of ad-

vanced years must be considered as indicating a potential diminution in excretory ability and thus inability to withstand damage from the drug.

In the table which we present the age of 50 years has been arbitrarily chosen as a convenient point at which the potential renal weaknesses of old age may, for the purposes of sulfonamide treatment, be said to begin. In actual practice, however, one should of course study his individual patient and whenever it is possible attempt to detect evidences of actual renal damage. In the presence of definite nephritis great care should be used in the use of the drug if, indeed, it is wise to use it at all. In every case the physician faces the problem of weighing the need for sulfonamide treatment against the risk involved in its use, and when he is faced with a situation in which he decides that the drug must be given, despite the known risk, he should use extra precautionary measures such as we shall discuss. The basis for these precautions is found in the following known facts concerning the fate of the drug in the human body.

When sulfadiazine is given to man it is absorbed and excreted more slowly than most other sulfonamides. In the body it is detoxified by acetylation and the excretion, almost entirely by the kidney, is about 70% free drug and 30% acetylated. The acetylated drug is not active against bacteria. After stopping the drug it is all excreted in 48 to 72 hours by a normal kidney, but may not be all excreted for many days by a damaged kidney.

When dosage is begun and maintained, for example, at 1 gram every four hours, it takes about 48 hours to be distributed in the body water and for excretion to equal absorption. Equilibrium is reached somewhat sooner if sodium sulfadiazine is given intravenously. A larger initial dose has been used by most to reach a higher amount of drug in the blood stream more quickly.

We have been able to show that patients vary widely in the amount of drug in the blood when equilibrium is reached on any particular dosage. After 1 gram every 4 hours for at least 3 days the amount of free sulfadiazine $3\frac{1}{2}$ to 4 hours after a dose may be as high as 17 mg. per 100 c.c. of blood or as low as 2 mg. per 100 c.c. Urinary

*From the Medical Service and the Laboratory of the Rhode Island Hospital, Providence, R. I.

TABLE I

	Sulfadiazine Dosage				NaHCO ₃ with each dose of Sulfa- diazine	KHCO ₃ with each dose of Sulfa- diazine	Fluids	
	Over 50 Years Old		Under 50 Years Old				Oral	Intravenous* Per Day
	Initial	To Follow	Initial	To Follow				
UNCOMPLICATED CASES	2 gm.	1 gram every 4 hours	2-4 gm.	1 gram every 4 hours	5-10 gm.	0	Forced	If necessary
DEHYDRATION	0	1 gram every 6 hours	0	1 gram every 4 hours	5 gm.	0	Forced	3+ liters 3+ liters
NEPHRITIS	0	1 gram every 6 hours	0	1 gram every 6 hours	0	1 gm.	Forced	Enough to give 1500 c. c. urine
CARDIAC DECOM- PENSATION	0	1 gram every 6 hours	0	1 gram every 4 hours	0	1 gm.	Forced	Enough to give 1500 c. c. urine No NaCl
MALNUTRI- TION, HYPO- PROTEINEMIA	2 gm.	1 gram every 4 hours	2 gm.	1 gram every 4 hours	0	1 gm.	Forced	Enough to give 1500 c. c. urine Not over 9 gm. NaCl
NO ORAL INTAKE	0-2½ gm. Sodium Salt I. V.	2½ gm. every 12 hours I. V.	2½ gm. Sodium Salt I. V.	2½ gm. every 8 hours I. V.	0	0	0	3+ liters NaCl only if indicated

*Intravenous fluids should be given mainly as 5% glucose in water with isotonic NaCl only when indicated, 10% glucose only when extra carbohydrate seems necessary.

output explains part of this variation, but not all of it, and one cannot predict the amount in blood with any accuracy.

Sulfadiazine is soluble in urine, at pH 6 and body temperature, to the extent of 39 mg. per 100 c.c. At pH 8 the solubility increases to 64 mg. per 100 c.c. Because of this, NaHCO_3 by mouth has been used to increase the amount which can be excreted before a saturated solution and crystal formation are reached. If we make an assumption of 100 times concentration of glomerular filtrate by the kidney, then crystal formation in urine will occur when blood sulfadiazine exceeds 3.9 mg. per 100 c.c. with urine output of 1000 c.c. at pH 6.

Patients with hypoproteinemia or cardiac decompensation should have sodium restriction. The use of NaHCO_3 to alkalinize the urine is contraindicated. KHCO_3 may be used, but only in small dosage and with care. With the above points in mind we have attempted to formulate a set of rules to govern the use of sulfadiazine at Rhode Island Hospital to prevent kidney or other untoward complications:

1. Do not use sulfadiazine unless it is definitely needed for therapy.
2. Do not give a large initial dose to dehydrated patients, or to those with cardiac decompensation, or a history of kidney damage.
3. Treat dehydration with intravenous fluids before starting the drug.
4. Watch urine pH, 24-hour volume, and color carefully. Use alkalis to raise a low pH, fluids to increase low 24-hour volume, and examine any red or brown urines for hemoglobin and cells. Initial urinalysis is especially important in patients getting sulfadiazine. The finding of crystals of sulfadiazine or acetyl sulfadiazine is not significant.
5. NaHCO_3 , up to 10 grams with each dose of sulfadiazine, should be given to all patients without cardiac decompensation or edema. Some patients with an infection will still excrete an acid urine while getting 60 grams per day of NaHCO_3 .
6. When edema or cardiac decompensation is present KHCO_3 , not over 10 grams per day, should be used instead of NaHCO_3 . If the patient is getting digitalis, the KHCO_3 should be limited to 5 grams per day.
7. When no oral therapy is possible, sodium sulfadiazine intravenously supplies the sodium, and, unless otherwise indicated, sodium lactate should not be given. (We have had two patients who have developed alkalosis after the use of both.)
8. An initial blood count need be checked only after a week, unless otherwise indicated. The blood dyscrasias develop after 7 to 10 days of

treatment. If white cell count falls from normal to less than 3,000 the drug should be stopped.

9. Ammonium chloride therapy for relief of edema and NaHCO_3 for alkalization are incompatible. KHCO_3 will do both of these jobs.

10. Urine pH should be done as a bedside procedure on all cases. This is a simple matter with nitrazine paper or Fisher Alk-Acid test paper, and can be recorded by the nurse or orderly for later reference.

11. Determination of the amounts of free and acetylated drug in the blood should be done after the first 24 hours and about every two days thereafter, *only* when a therapeutic effect is not evident, or when there is reason to believe the drug will be excreted poorly. Normally less than 1 mg. per 100 c.c. of blood is present in acetylated form, but in cases with poor kidney function the acetyl sulfadiazine is excreted more slowly than the free and values over 1 mg. per 100 c.c. of blood indicate possible renal complications.

12. Water by mouth and sugar solutions by vein are the best treatments for anuria, if it develops. Should these fail, plasma or concentrated plasma should be tried. Other aids of special use are concentrated sodium chloride solutions by vein, diathermy to the kidneys, transfusion, or even decapsulation of the kidney. One of our cases would indicate that retrograde pyelography and lavage of the kidney pelves and ureters with dilute bicarbonate solution should be tried if other methods fail.

These recommendations are detailed in tabular form on the preceding page. We have arbitrarily divided patients into those over 50 years of age, where renal complications are more frequent, and those under 50, where they are comparatively rare.

PUBLIC HEALTH ASPECTS OF RHEUMATIC FEVER

continued from page 17

- ⁵ Holbrook, W. P., J.A.M.A., 126: 84, 1944.
- ⁶ Coburn, A. F., *ibid*, p. 88.
- ⁷ Quoted in *The Epidemiology of Rheumatic Fever and Some of its Public Health Aspects* by J. R. Paul. Metropolitan Life Insurance Co. Press, New York, 1943, p. 134.
- ⁸ Hedley, O. F., Pub. Health Rep., 54: 2271, 1939.
- ⁹ cf. Ref. 7, p. 136.
- ¹⁰ cf. Ref. 7, p. 50.
- ¹¹ Hedley, O. F., Pub. Health Rep., 53: 1635, 1938.
- ¹² Robertson, O. H., The Harvey Lecture Series, 38: 227, 1942-43.
- ¹³ London County Council. "Annual Report of the Council for the year 1936". Public Health Rep., 3: Part 2, London, 1937. *Ibid*, 1938.
- ¹⁴ cf. Ref. 7, Chap. XII, p. 107.
- ¹⁵ Huse, B., Am. J. Pub. Health, 31: 809, 1941.

WHAT OF THE DOCTOR-VETERAN?*continued from page 14*

on these younger men as assistants, thus permitting them gradually to re-establish themselves educationally and economically.

For other returning doctors the rigors of private practice will be eliminated because of disabilities incurred in the line of military duty. These men will merit our special attention. They should be trained and then given preference for established positions in hospital, public health, institutional, industrial and allied fields. These men will not want such positions as a form of recompense for service to their country, or as a charity grant, but I am sure that if they are allowed to specialize in such activities and to utilize fully their professional training they will welcome the opportunity.

From these few limited observations I am sure that you will agree with me that the problem is not only important, but it is one of many ramifications. Therefore, I recommend that the Association, in the immediate future, consider the advisability of establishing a War Veterans Committee which would have as its purpose the extension

of every possible aid to enable the doctors of this Association to re-establish private practice in our communities upon the completion of their services with the armed forces. I would suggest that the personnel of such a committee include, among others, officers of the Association, someone versed in hospital opportunities, executives of State, and municipal and private institutions, a doctor familiar with medical needs and opportunities in industry in this highly-industrialized state, and most important of all, a doctor-veteran who will know what returning doctors should have when they return to civilian practice.

* * *

With these remarks I conclude my term of service as President of this Association, but before I relinquish this office to my successor I take this opportunity to publicly thank the officers, the executive and other committees, the executive secretary, and all of you who have ably assisted me during the past twelve months in the administration of my duties. I shall long cherish the honor you have bestowed upon me.

MID-WINTER MEETING

At the Medical Library . . . MONDAY, FEBRUARY 5, 1945, at 8:30 P. M.

(Joint meeting of the Rhode Island Medical Society
and the Providence Medical Association)

**"LESSONS LEARNED IN THE TREATMENT OF BURNS FROM THE
HARTFORD CIRCUS DISASTER"**

* * *

ORGANIZATION AND SURGICAL PROBLEMS

DONALD B. WELLS, M.D., *of Hartford*

BACTERIOSTATICS and MEDICAL PROBLEMS

JOHN C. LEONARD, M.D., *of Hartford*

LABORATORY PROBLEMS

RALPH E. KENDALL, M.D., *of Hartford*

ESPRIT de CORPS IN CATASTROPHE

MAURICE T. ROOT, M.D., *of Hartford*

(A motion picture of the disaster will also be shown)

"PRACTICAL ASPECTS OF THE TREATMENT OF SHOCK"

CHARLES A. JANEWAY, M.D., *of Boston*

(Member, Staff, Children's Hospital, Boston)

The RHODE ISLAND MEDICAL JOURNAL

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THE GOVERNOR'S MESSAGE

THE discussions on Hospitalization and Cash Sickness in the message of Governor McGrath to the General Assembly at that start of the current session should receive thoughtful consideration by everyone interested in these programs, and certainly by every physician in the State who, by the very nature of his calling, is necessarily the most important factor in any such plans.

The Voluntary Advisory Council on Health which had its genesis in the Porter proposal made a year ago has reportedly studied the hospitalization recommendation of the Governor closely. It is gratifying to note that the Governor publicly has paid tribute to the subcommittee of this Council which numbers several of our members for its hours of intensive study of his proposal during the past year.

Significant in the Governor's message is his statement that "it is obvious that no plan of universal prepaid hospitalization can be put into effect until we are sure that the services for which prepayment is made can be met by adequate facilities". From this we are to conclude that no hasty legislation will be prompted, but on the contrary any law now contemplated will call for a future operative date contingent upon the expansion of hospital accommodations, and more important, the medical and

nursing personnel to service adequately such expanded facilities.

This contemplated expansion of buildings and personnel will call for a corresponding increase in funds for operation. That fact must be closely noted as the study of the compulsory program continues. We are sure that the hospitals will hardly proceed with plans to meet an increased demand predicated on a compulsory requirement for workers "confident (as the Governor stated) that their investments in plant and facilities can and will be supported by those who make use of them." The Christian charity which was the basis for the institution of the first hospitals in the sixth century still prevails. Today all our hospitals still depend upon the philanthropy of the community to assist in the expenses of operation.

Private insurance, the Blue Cross, and even the proposed federal hospital plans call for only part payment of the cost of hospitalization, and in no instance does the total payment by the insurer and the patient meet the per diem cost of hospital maintenance. Hence, if philanthropy is discouraged by reason of compulsory contributions from the many, the hospitals must seek other revenues if they are to maintain high standards in operation. Higher insurance rates and increased taxes would be the main sources for such revenues.

The Governor's remarks on the Cash Sickness Compensation program indicate only too clearly the difficulties arising from legislation not thought through before its enactment. He has indicated some of the faults in the program—faults that have been pointed out by physicians on numerous occasions during the past two years. The bulk of the work—and most of the criticism—for the success or failure of the plan has fallen upon the medical profession which has been handicapped by both the broadness of the legislation and by the unrestricted interpretations of it by the administering board. It is to be hoped that any amendments aimed at correction will have the benefit of medical advice.

The further recommendation of the Governor that a Board of Directors, men experienced in finance, with wide discretionary fiscal powers, be created by the Assembly to administer the Sickness Fund by establishing policies affecting its investment and use, is noteworthy. The idea that public funds can only be administered efficiently by the State through its political divisions is a fallacy that should be permanently exploded. As trustee of large sums demanded from the workers to provide for their security the State truly has a grave responsibility to call into service on a voluntary or paid basis outstanding trained citizens to establish sound policies devoid of any political or personal ramifications. Governor McGrath is to be congratulated for such forward thinking on a vital problem of concern to every resident of Rhode Island.

SPARE THE KNIFE

There have been a number of cases in our midst lately where severe hemorrhages have occurred in the lower rectum following the injection treatment of hemorrhoids with sclerosing solution. One of these episodes led to a wholesale recruiting at a local theater where the situation (minus the intimate details) was broadcast and volunteers responded nobly. Imagine the pleasing excitement of the theater audience who sat in on or even participated in this drama, and what a fine story it made in the next day's paper, even though little recognition was given to the outstanding work of the hospital staff in accepting such an unexpected influx of blood donors on Christmas day!

How dull the episode if the patient had merely had the piles removed and after a few days of moderate discomfort had been well. We say "moderate discomfort" for since the day of the rectal tube, which the late Dr. Binnie of Kansas City said "should be reserved for malefactors and personal enemies", that is usually the situation.

And besides the hemorrhages many cases are being referred of fistulae and perirectal abscesses where sometimes medical men, but probably more

often in our community osteopaths, have injected people who "fear the knife". It follows from this "fear of the knife" that many growths on the surfaces of the body which could be quickly cut out, leaving clean scars, are treated by cautery, dessication, etc., with long healing and large scars resulting. But the patients feel they are avoiding surgery when as a matter of fact all the treatments are surgical, but in disguise.

There is a good old New England saying that "lazy folks take the most pains". What could be accomplished promptly and efficiently by a bold, energetic process is partially and slovenly done with the end result the expenditure of extra energy. Similarly we might say "timid folks take the most chances". The examples we have cited above happen to be in favor of the surgeons. It is not always so. The dermatologists have done striking work with sclerosing agents and carbon dioxide snow treating hemangiomas previously poorly handled by surgeons. And surgeons, really timid, insist on doing frequent dressings when the seemingly bold, but actually conservative thing is to keep hands off, allowing wounds to continue healing; not tearing into granulation tissue and opening up sources of infection.

As little Buttercup says, "Things are seldom what they seem." The prick of the hypodermic needle seems so much simpler than cutting and sewing. But sloughing tissue in a dirty area is dangerous. It seems natural to keep a close eye on our handiwork but Dr. Winnett Orr has shown us that it is dangerous to keep peeking. However, a careful estimate of the basic medical and surgical principles will usually lead us aright.

A STUFFED SHIRT

One of our associates recently referred to Dr. Oliver Wendell Holmes as a "stuffed shirt". In our opinion there seldom was a less apt expression. Lacking access to a dictionary of American slang we would say that a "stuffed shirt" was a four-flushing, bombastic type of fellow really having little ability but putting up a big front—a piece of cloth padded out until it appears as though there might be a real man inside.

This was apropos of the recent biography of the doctor's son, Justice Oliver Wendell Holmes. People who profess to understand what lawyers say speak with admiration of the dissenting opinions of Justice Holmes. We are inclined to accept their opinion of his greatness. He followed for once his father's advice and chose his ancestors with care and discrimination and the result in his case was an orthodox one.

But to our mind there was one great flaw in his judgment and character. The late Alexander Woolcott, and the authoress of a *Yankee from Olympus*,

continued on next page

show pretty conclusively that he did not like or esteem his remarkable father. The authoress certainly damned with faint praise the elder Holmes. In an introductory paragraph before each installment of her book in the *Atlantic Monthly* she referred to him (we quote from a fallible memory) as "a writer of good books and bad verse". Dr. Samuel Eliot, in a letter to the editor, protested that it was hardly fair to characterize as a "writer of bad verse" a man who produced *Old Ironside*, *The Chambered Nautilus*, and one of the great hymns of the English language—"Lord of all being throned afar!"

The most gentle and kind of men, there is hardly a bitter word in all his prolific writings, and yet he was so bold in his opinions that he aroused strong feelings of disapprobation in those who did not agree. Besides his poems, his *Autocrat* is a delightful classic, practically as familiar now as when he was writing. For 35 years he was professor of anatomy at Harvard Medical School and his lectures were thronged and are still a byword there. He ante-dated Semmelweis with his paper on the *Contagiousness of Puerperal Fever*.

Such a man warranted the approbation of his son, and was not a "stuffed shirt".

THE JOURNAL ADVERTISERS

The re-organization of the JOURNAL during the past twelve month period has attracted wide attention. Every effort has been made to increase the number of excellent scientific articles that have long made the JOURNAL one of the best edited in the country. New developments have been fostered in the field of medical-economic reporting. The extremely important Industrial Health section has set the pace for renewed thinking and planning in this phase of medical service so pertinent to such a highly-industrialized state as that of Rhode Island. The popular Doctors At War section, the Hospital, Dental, Library, District Society, and others have all added to make the JOURNAL most readable.

But of equal importance is the advertising copy that is presented each month, not for the financial return to make possible the publication cost so much as for the informational value it offers the busy doctor. Too little is known by most doctors of the tremendous research in advertising that is completed before final copy is approved by ethical pharmaceutical houses for their products. The fine displays presented each month represent detailed study of the product as well as authoritative pronouncements of its reported medicinal value.

For today's busy doctor whose crowded office hours allow little time for discussion with those detailing pharmaceutical products, the displays in

the JOURNAL offer an excellent way in which to obtain reliable information on products in general use by the medical profession, as well as new products stemming from the unceasing research in pharmacy and allied fields.

This month we introduce several new advertisers to our membership, and we also present many displays in color which not alone serve to attract attention to the product offered, but by their attractiveness of layout and design embellish our JOURNAL. To the doctor who has not acquired the habit of reading the ads we urge this act as an important New Year resolve.

CLINICAL INFORMATION BUREAU

The action of the Massachusetts Medical Society, as reported in the announcement on page 49 deserves special commendation. In creating a Bureau of Clinical Information at its headquarters at 8 Fenway, where a telephone inquiry will result in prompt official information as to the daily activities of the approved hospitals in Boston and its immediate vicinity the Society has made a noteworthy contribution to the postgraduate education of the doctors of Rhode Island as well as Massachusetts.

The post road to our larger neighboring city has been well travelled through the years by our doctors who have sought to augment their knowledge of clinical medicine at the major hospitals in this important medical center. To be able now to call a central office the night before a visit, or even hours before, and thereby to know of operations for the day, of medical and surgical ward rounds, of the location of clinics, as well as the names of those presiding over these various activities, is certain to make our visits more profitable and more frequent.

AIR TRAVEL AND THE DOCTOR

The announcement of the Civil Aeronautics Administration of a national airport plan to provide more than 3,000 airports and to improve approximately 1600 existing fields throughout the country offers reason for serious thought regarding the planning of the distribution of medical services in the years ahead. The CAA plan envisages at least one airport in 88% of the counties of the United States. For Rhode Island the plan would improve the seven existing fields and create eleven new airports.

With Block Island as our only outpost and with the remainder of the state accessible by motor travel within an hour and a half's time from any other part, it is to be doubted that the Rhode Island physician will turn to air travel as a means of expanding his territorial practice. Unless, of course, state licensure regulations are altered to permit unlimited reciprocity.

However the possibilities involved for making available medical services to rural areas by air travel in our larger states should prove challenging to many young doctors. Consider the conservation of time and energy by the cooperative effort of physician and patient in the utilization of both air and auto travel. The busy doctor might range over a wide radius operating from an urban center, or the patient might be swiftly and comfortably moved from a remote area to a treatment center.

The mere discussion of the program stimulates theories for future planning. At the same time it gives reason for urging caution in present planning predicated on existing or past programs. For example, the idea of a hospital in every county falters in view of the simpler procedure of expansion of centralized units with air travel for the physician or patient, whichever is more advantageous in each instance. Likewise the recommendations so freely made during the past year in some parts of the country for a single licensure standard must be guarded against in the light of possible speedy inter-state air travel by the individual physician whose method of transportation might be far more advanced than his clinical training in medicine.

INDUSTRIAL HEALTH SEMINAR

The general awakening of industry throughout the country to the long neglected issue of industrial health is of extreme importance to Rhode Island physicians. In the past decade, and particularly in the past three years, we have witnessed a marked educational advance by labor and management regarding the vital importance to the welfare and health of all employees of their health while on the job. The adoption of safety appliances and the establishing of first aid rooms with full time nurse service and physicians in regular attendance, are rapidly disappearing from the category of "extra or luxury service" to their rightful place as necessary factors in the well-rounded scheme of successful industrial organization.

Rhode Island has a premier stake in the field of industrial health and safety, for it exceeds every other State in the country in per capita industrial output. The announcement, therefore, of the Society's Committee on Industrial Health, in conjunction with the Rhode Island Society of Industrial Physicians and Surgeons, of a postgraduate seminar in industrial health at Brown University during the next two months should evoke the interest of every physician, nurse and industrialist. The development of such a program under the auspices of the department of medical sciences at Brown University marks a forward step in medical-industrial relations that may well set a pattern for the country.

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CENTENARY CELEBRATION OF HORACE WELLS, 1844-1944*

AMBROSE H. LYNCH, D.M.D., F.A.C.D.

The Author. *Ambrose H. Lynch, D.M.D., F.A.C.D.,
Former President, Rhode Island State Dental Society.*

*"Can Storied Urn, or Animated Bust,
Back to its Mansion, Call the Fleeting Breath?
Can Honor's voice provoke the silent Dust,
Or Flatt'ry soothe the dull cold ear of Death?"*

Thus the philosophic introspection of the Elegyist.

* * *

MR. President, Mr. Toastmaster, members and guests of the Rhode Island State Dental Society: We are meeting here tonight, as are many other dental societies in the country in conformity with the design of the Horace Wells Centenary Committee of the American Dental Association, to honor Wells for his great work in the discovery of anesthesia. This year, the American Dental Association plans to bring more fully and clearly, to the attention of the public in general, as well as to the Dental profession, the facts concerning the discovery by Dr. Wells, and his historic contribution in the field of Dental and Medical Science.

You have no doubt, by this time, read in our Journals and magazines, many facts about the work Wells did, which will cover the field much abler than I could hope to do.

Perhaps, I may touch more upon the man — his triumphs and tragedies.

Horace Wells was born at Hartford, Windsor County, Vermont near the confluence of the White and Connecticut Rivers, amongst the Vermont hills, of which the poet sang: 'The hills, rock-ribbed and ancient as the sun, The vales, stretching in pensive quietness between;' on January 21st, 1815, the first of three children, the others being a brother Charles, who became a physician, and a sister Mary; born to Horace and Betsy Heath Wells.

He descended from true New England stock. His ancestors were among the earliest settlers of Vermont. His father was a leading citizen, and owner of a large and valuable farm near the Connecticut River. His children therefore, were able to obtain the best educational advantages of the time.

*An address presented before the Rhode Island State Dental Society on the occasion of the Dr. Horace Wells' Centennial Dinner, at Providence, December 11, 1944.

At one time in his early youth, it is said that he contemplated studying for the ministry. But, his benefactions to humanity were to be in other channels. He, no doubt had read Portia's observations —

"If to do were as easy as to know what were good to do, Chapels had been Churches, and poor men's cottages Prince's palaces. It is a good divine that follows his own instructions."

However, instead he decided to study dentistry and went to Boston, Mass. for that purpose. This was in 1834, which was six years before the first Dental College at Baltimore, Maryland, was established. Wells at this time was 19 years of age. At that time, preparation for a career in dentistry was in serving an apprenticeship in the office of a recognized practitioner. This was even optional. With whom he studied in Boston, is unknown. It is thought that he was one of the so-called "Traveling Dentists", current at that period, after his training in Boston and before he located in Hartford, Conn. in 1836, at the age of 21 years. It seems quite a coincidence, that Wells was born in Hartford, Vermont and made his discovery and had his success in Hartford, Conn. and found his final resting place there, enshrined with eternal honors.

He is described about this time, as "somewhat above the average height, heavy set and fairly handsome. He had high color, curly hair and a pleasant bearing, although extremely sensitive and shy, he seemed to make friends easily. Another characteristic was an inquiring and inventive mind, always seeking the new.

He is said to have invented and personally constructed many of his dental machines and instruments."

He also seemed to be a pretty good business man. He invented and obtained U. S. patents for a coal-sifter in 1839 and a shower bath in November 1846. The operation of the shower for the bath was quite a contraption.

According to his business records and letters to his mother, he was earning more than \$100 a week, which in 1836 must have been equivalent to at least 3 or 4 times that amount in our present day. However, at the time of his death, he was insolvent.

As I read the life of Wells, the recurring thought was: how similar were his characteristics, to those

of another great scientist and discoverer, also of the 19th century, whose life was contemporaneous with Wells (1815-1848). His name is Louis Pasteur (1822 to 1895).

Pasteur's experiments brought forth a new era in science too, which served to make all our lives safer and happier. If it were not for his historic discovery and elimination of the then ruthless killers of an unseen world, millions of his and our generation would not have survived. He ranks as the founder of the branch of science known as Bacteriology.

After Wells became established in Hartford, Conn., and became one of the leading dentists in the community, he had several students of dentistry in his office, as apprentices, among whom was William T. G. Morton, then of Farmington, Conn., near Hartford, and John M. Riggs, later associated with the so-called 'Riggs Disease'. The first was later to be one of Wells' rivals for the claim as discoverer of Anesthesia, while the other was to become his lifelong friend and champion.

Later Morton went to Boston and opened an office, in partnership with Wells. But, the partnership was very soon dissolved.

Wells never closed his Hartford office. He seems to have permitted the use of his name however, to help Morton get established; and to have done some of Morton's work, at his own office in Hartford.

During this early period of his life, Horace Wells gave evidence, by the letters he wrote to his family, (he had lost his father, by death, when only 14) of his intense desire to improve his mind and character by extensive reading of books of high quality, of great seriousness. Books, of which he wrote, were such as—"to improve my mind and help me grow in grace." Such thinking had undoubtedly brought about the constant thought of finding a way in this Egyptian darkness, to eliminate the pain accompanying dental procedure. In 1836, at the age of 21, he had written and published "An Essay on Teeth".

Colton's Advertisement the Stimulus to Experiment

Wells had been seeking for some drug that could be used, in some way, to deaden this pain and had discussed the matter with a professor of chemistry at what is now Trinity College in Hartford. It is fair to conjecture, that Wells had some knowledge of the experiences of the chemists and physicists; such as Priestley, Davy and Faraday who were working with various gasses in 1818, for in justifying his claim later about being the discoverer of inhaling Nitrous Oxide, said, "while reasoning from analogy, I was led to believe that the inhaling of any exhilarating gas, sufficient to cause a great nervous excitement, would so paralyze the

system as to render it insensible to pain or nearly so."

Hence we may be sure that his reasoning and inquisitive mind had received a stimulus along such lines as he read in an advertisement in the Hartford Courant, as of December 10, 1844, which was as follows:

"A grand exhibition of the effects produced by inhaling Nitrous Oxide, Exhilarating, or Laughing Gas!! will be given at Union Hall this Tuesday evening, December 10, 1844.

"Forty gallons of gas will be prepared and administered to all in the audience who desire to inhale it. Twelve young men have volunteered to inhale the gas, to commence the entertainment.

"Eight strong men are engaged to occupy the front seats to protect those under the influence of the gas from injuring themselves or others. This course is adopted that no apprehension of danger may be entertained. Probably no one will attempt to fight.

"The effect of the gas is to make those who inhale it, either laugh, sing, dance, speak or fight, etc., according to the leading trait of their character.

"They seem to retain consciousness enough not to say or do that which they would have occasion to regret."

N.B. "The gas will be administered only to gentlemen of the first respectability. The object is to make the entertainment in every respect a genteel affair."

The advertisement further declared that Mr. Colton, who was offering the entertainment had given such demonstrations to audiences numbering over 4000 ladies and gentlemen in New York City and will be the first to inhale the gas.

"The entertainment is Scientific to those who make it scientific"—and, we are quite sure, such it was to Horace Wells at the "Cost of admission—25 cents—tickets on sale at the principle bookstores and at the door."

Mr. Colton describes the chemistry of Nitrous Oxide and begins the demonstration. Volunteers are asked to step up to the platform. The first happens to be a drug clerk of Hartford, Mr. Samuel A. Cooley. He is handed the bag containing the gas, which Colton himself had demonstrated how to use, and instructed Cooley to take a few deep breaths of its contents. Cooley does so, and suddenly a violent change comes over him. He jumps from the platform, barking his shin and runs about, quite unconscious of his actions. Soon the effects wear off and by a most fortuitous chance, sits down next to Wells, while the show goes on. Here is where the inquiring mind of the true scientist goes to work. In the mind of Wells, as it did in the mind of Pasteur. So Wells asked Cooley, "if he had felt any pain when he hurt himself?"

continued on page 29

WHEN BETTER IS AVAILABLE..

DEMAND IT!

COMFORT+

DENSER CASTINGS...

STEEL DIE ACCURACY...

CAST OR WROUGHT CLASPS...

EASY TO SOLDER...



TICONIUM

402 North Pearl Street, Albany,

THERE IS A TICONIUM LABORATORY NEAR YOU

"Not a thing," answered Cooley. Here is the spark that ignites the smoldering idea of No Pain. Wending his way homeward that night, can we envision Wells, beating a rhythmic foot-fall, with every step—No Pain—No Pain—No Pain!

Hamlet soliloquized—

"To sleep!—perchance to dream: ay, there's the rub:

For in that sleep—What dreams may come."

What thoughts and hopes must have paraded through the Doctor's mind that night?

Fitfully, he awaits the break of dawn, the dawn of that memorable day, Wednesday, December 11, 1844.

That tooth which has been troubling me—"yes, yes I'll try that gas of Colton's. So that morning, Wells obtains the gas from Colton, as well as the presence of Colton, and his inspiration, Samuel Cooley, to view its use, for quite another purpose, the extraction of his (Wells') own tooth. His colleague, Dr. Riggs has consented to cooperate in the affair. One version is, that Wells took the gas bag in his lap, held the tube in his mouth, and inhaled till he reached the stage of insensibility. The other is, that Colton administered it to him. When the time seemed opportune, Dr. Riggs reached into Wells' mouth and extracted the tooth, an upper third molar.

The visitors were amazed. They were spectators of the first surgical anesthesia. Anesthesia for surgical operations had been discovered and demonstrated.

Once again, the thought intrudes of Pasteur. His first use of the hydrophobia serum on a living human being. His anxiety of mind, that perhaps death might ensue to the patient. So must Horace Wells have thought of himself—yet, even the thought of death itself did not deter him from carrying out his experiment.

All hail the courage of men like these, who represented a brotherhood of science, labouring to diminish the sorrows of humanity, and to prevent human suffering, as far as possible.

Encouraged by the result of this first use of Nitrous Oxide as an anesthetic, both Wells and Riggs continued to administer it to various individuals, for extractions and other surgical operations.

Here is what Wells wrote about his discovery. "On making the discovery I was so elated respecting it, that I expended my money freely and devoted my whole time for several weeks in order to present it to those who were best qualified to investigate and decide upon its merits, not asking or expecting anything for my services, well assured that it was a valuable discovery. I was desirous that it should be as free as the air we breathe."

So, fully satisfied with the use of the gas, Wells hied to Boston, to tell his former associate Morton, and others, of his success. This resulted in a demonstration before the class of senior Medical Students at Harvard.

Many of you no doubt recently saw the movie called, "The Great Moment" which portrayed his unsuccessful demonstration then, and the hostility of the medical men of the day towards his discovery.

This unfortunate experience deeply hurt the sensitive nature of Wells, and he returned to Hartford, disconsolate and discouraged, which brought on illness which necessitated giving up his practice for months. But, the fire of new thought and method had been lighted and left burning.

Morton and others had been stimulated to go on with further experimentation. This Morton did using ether in much the same manner, which later caused much controversy and recrimination.

It was conceded however, by many distinguished scientists and medical societies that Wells was the pathfinder and should receive the credit for the discovery.

There are those who claim that the monument on Boston Commons, in our neighboring Commonwealth—"To the Discoverer of Anesthesia" is in reality a monument to Wells. From my own recent observation of it, I do not think that it is so.

The monument was erected by a citizen of Boston—a Thomas Lee, in 1867—"In Gratitude for the Relief of Human Suffering by the Inhaling of Ether." From the history at hand, it appeared that there was controversy still raging, even in 1867 and that no person by name was credited with the honor on the monument.

But we do know that Dr. Morton was the one who received the honor of first demonstrating the use of Ether, at the Massachusetts General Hospital in Boston, in October 1846.

Horace Wells divorced himself from the practice of dentistry, for some time, following his unfortunate Boston experience. He engaged his talents in a series of entertainments and promotion of his patents, i. e. the coal-sifter and shower bath. His mother's observations were, "He thinks he is now on his way to fortune, but I fear he is building castles in the air, which will soon burst." "I can do nothing but leave him in the hand of God."

During such business trips he made a visit to New York City in the summer of 1846. While there he called on Dr. Valentine Mott, and acquainted him with the influence of Nitrous Oxide and Sulphuric Ether for surgical operations. He likewise made a visit to Paris in 1847, to present his claim for the discovery of anesthesia, in conjunction with another mission.

continued on page 36



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PROGRAM OF THE 66TH ANNUAL CONVENTION of the RHODE ISLAND STATE DENTAL SOCIETY

JANUARY 23-24, 1945

TUESDAY, January 23, 1945

Narragansett Hotel Clubroom

- 7:00 P.M. Motion Picture — "IMMEDIATE DENTURE SERVICE"
University of Minnesota, School of Dentistry
- 7:30 P.M. BUSINESS MEETING, nomination of officers, recess
- 8:15 P.M. *Speaker* — Irving Glickman, B.S., D.M.D.
Assistant Professor of Oral Pathology, Tufts Dental School. Lecturer,
Forsyth School for Dental Hygienists.
- Subject* — "THE PRINCIPLES UNDERLYING THE TREATMENT OF PERIODONTAL DISEASE" WITH LANTERN SLIDES.
- Dr. Irving Glickman is recipient of the Third Annual Prize Essay Competition of the Chicago Dental Society. The title of his paper was "The Systemic Influence Upon Bone in Periodontoclasia."

(Business Meeting Continued If Necessary)

WEDNESDAY, January 24, 1945

- 9:00 A.M. REGISTRATION, continued all day, necessary for admission.
- 9:30 to 11:30 A.M. *Subject* — "GOLD INLAYS, CAVITY PREPARATION, DEVELOPMENT OF WAX PATTERNS"
Clinician — Robert C. Lonergan, D.D.S.
Chairman — A. James Kershaw, D.D.S.
- 10:00 to 11:00 A.M. *Subject* — "ONE METHOD OF MEETING A POST-WAR PROBLEM."
Clinician — H. Shirley Dwyer, D.D.S., F.I.C.D.
Chairman — Arthur Johnston, D.D.S.
- 11:00 to 12:00 A.M. *Subject* — "EXODONTIA AND MINOR ORAL SURGERY"
Essayist — Wells Daniels, D.M.D.
Chairman — Paul E. Cote, D.M.D.
- 12:00 to 1:30 P.M. PAST PRESIDENT'S LUNCHEON
Guest Speaker — Robert F. Lybeck, B.S., Boston, Mass.
He is the Representative of Colonial Oil Co. on Aviation. A member of the Automotive Engineers Society and a member of Tufts College Alumni. Has been connected with the petroleum field for 25 years.
- Subject* — "YOU WILL FLY"

Afternoon Session

- 1:30 to 3:00 P.M. *Subject* — "FULL DENTURE CONSTRUCTION" with slides
Essayist — Leonard Gray, D.D.S.
Chairman — Donald Osborn, D.M.D.
- 3:00 to 4:00 P.M. *Subject* — "EXTRACTION IN ORTHODONTIC TREATMENT" with slides.
Essayist — Samuel Fine, D.M.D.
Chairman — William Moranville, D.M.D.

continued on next page

- 3:00 to 4:00 P.M. *Subject* — "FLUORINE AND DENTAL CARIES" with slides
Essayist — John W. Knutson, D.D.S., DR.P.H.
Chairman — Frank F. Bliss, D.M.D.
- 4:00 to 5:30 P.M. *Subject* — "ACRYLICS IN GENERAL DENTISTRY"
Essayist — Fred Slack, Jr., D.D.S.
Chairman — Norman H. Fortier, D.M.D.
- 5:30 P.M. BUSINESS MEETING resumed, election of officers.

Evening Session

- 6:30 P.M. BANQUET. Narragansett Hotel.
Guest Speaker — John E. Farrell, A.B., Executive Secretary, Rhode Island Medical Society and the Providence Medical Association.
Subject — "DENTISTRY'S PROBLEMS FROM THE VIEWPOINT OF A LAYMAN".

There will be a continuous showing of the scientific motion pictures in the order listed:

1. "Procedures Employed in Finishing and Cementing Large Fixed Restorations"
 Dr. Herbert H. Kahnick, New York, N. Y.
2. "Removal of a Maxillary Cyst" Dr. Robert M. Fisher, New York, N. Y.
3. "Mouth Preparation for Porcelain Jacket Crown"
 Dr. Milton Cohen, New York, N. Y.
4. "Immediate Denture, Surgery and Prosthetics"
 Dr. William Ogus, Washington, D. C.

(Films 3 and 4 were loaned through the courtesy of J. J. Crimmings Co.)

ANNUAL CONVENTION COMMITTEES

The committees named by President Arthur M. Dring to plan the arrangements for the 1945 Annual Convention of the Rhode Island State Dental Society are as follows:

Convention Committee

Chairman, Dr. George J. Racicot
 1213 Main Street, West Warwick
Secretary, Dr. Charles F. McKivergan
 102 Waterman St., Providence

Program Publication

Dr. Arthur J. Johnston, Chairman, Warren
 Dr. Allyn F. Sullivan, Providence

Advertising

Dr. Paul E. Cote, Woonsocket
 Dr. Frank Bliss, Providence

Clinics

Dr. George J. Racicot, West Warwick
 Dr. Arthur J. Johnston, Warren
 Dr. Norman H. Fortier, Pawtucket
 Dr. Paul E. Cote, Woonsocket
 Dr. Donald D. Osborn, Providence
 Dr. William A. Moranville, Pawtucket
 Dr. Frank F. Bliss, Providence
 Dr. Allyn F. Sullivan, Providence
 Dr. A. James Kershaw, West Warwick

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PROVIDENCE

AN UNUSUAL CASE OF CHRONIC APPENDICITIS*

PETER PINEO CHASE, M.D.

The Author. *Peter Pineo Chase, M.D., Surgeon, R. I. Hospital*

Case History

29 years. Single, Saleslady.

Chief Complaint. Severe pain—right lower quadrant.

Present Illness. Completely well until yesterday A.M. when she had severe pain in right lower quadrant. Did not radiate, more or less continuous. No vomiting, diarrhea, or constipation. Pains intensified by physical activity. Urination has been painful.

Past History. No history of serious illness. For the past year or so she has been having some knife-like pains in her right side particularly when she walked. These pains evidently interfered little with her activities as all but a few inches of her external anatomy was well sunburned and she spoke enthusiastically of her swimming. Her menstrual periods have always been normal and the last were a few days ago.

Physical Examination. A slender athletic appearing young woman with nothing unusual in her physical examination except the local condition; extreme tenderness and rebound tenderness in the right lower quadrant.

Temperature—101

Pulse—92

White Blood count—11,000.

Diagnosis and Treatment

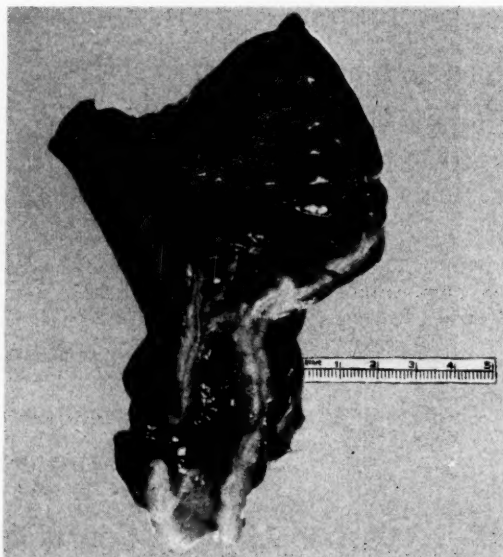
I am sorry to say that this is a typical case in that there is no evidence that a rectal examination was made.

The interne was indefinite in his physical exam but minutely definite in his diagnosis, stating that the appendix was gangrenous.

However sketchy the work up we were persuaded she had an acute appendix and operated.

A right rectus incision was made. The coecum was identified but could not be delivered. A large mass was felt running down into the neighborhood

of the Cul de sac of Douglas and it felt so like a carcinoma of the recto sigmoid that a careful examination of the large gut was made again. Normal anatomy of the coecum and terminal ileum was demonstrated. The mass was then found to be an appendix of practically wooden consistency and about 1¼ inches in diameter. With blunt dissection this was freed, the tip being torn away from the Cul de sac of Douglas. The induration was found to extend up onto the coecal wall for well over an inch. We did not know what the pathology was but we realized that we could not amputate the appendix in the usual manner because of this indurated tissue.



Therefore a mass amputation was made of terminal ileum, head of coecum and appendix. Side to side anastomosis was done and a tube placed in the terminal ileum. Abdomen closed tight.

The patient made a recovery that would have been satisfactory with any appendectomy. The tube was removed from the ileum on the 8th day and she was discharged on the 12th day.

At the pathology lab. the appendix was found to measure 8 cm. by 3 cm. The wall was up to 7 mm. thick. At one spot there was a defect in the wall

*Presented before the Providence Medical Association on December 4, 1944.

with a fecolith in the lumen and a small abscess cavity outside. The microscopical diagnosis was chronic appendicitis with perforation, peri appendiceal abscess and acute local peritonitis.

Conclusions

Chronic appendicitis is a source of great wealth for the surgeons. Indefinite recurring trouble in the right lower quadrant usually leads to a loss of the vestigial organ with presumably little disturbance of the conscience of the physicians involved.

It certainly is a rare appendix in which the pathologist cannot find evidence of chronicity. And yet there are skeptics who lift their eyebrows at the continuing series of interval appendectomies.

With us the past history of right lower quadrant trouble seems a point against the diagnosis when acute appendicitis is suspected. We feel that the real stormy attacks of acute appendicitis we have seen have usually come out of a clear sky. This case is presented as one where there is undoubted evidence of a chronic condition with an acute episode superimposed. It is also evidence that an appendectomy is not to be entered into lightly but discreetly and advisedly.

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HORACE WELLS CENTENARY

continued from page 29

While abroad, and after his return to this country, the pros and cons were flying for many months as to whom the honor of being the discoverer belonged.

In the winter of 1848 he removed to New York City, where he once again began the practice of dentistry, and continued further experimentation with Chloroform and the so-called "Letheon" Gas.

Fateful Day

The day is Friday, January 21, 1848—Does that date signify anything to you? It is Horace Wells' birthday—his 33rd—just beginning the flower of manhood; but Fate is casting a shadow across his pathway. The mind, once so keen and active, is now becoming clouded and confused, he is ensnared in soul and body, by the effects of self-experimentation with Chloroform. He commits a misdemeanor—sprinkles some acid on the shawls of a couple of bad little girls who parade lower Broadway—to drive them out, an idea of a friend of his. The hand of the Law is laid upon him. He paces a cell at the Tombs Prison, and this above all days—his glorious 33rd birthday.

Saturday, January 22nd

He asks to be allowed to go to his room on Chambers Street, to obtain some necessities. Yes, he does obtain them—also a razor and a bottle of Chloroform, unknown to his guard.

Sunday, January 23rd

Yes, this is the Lord's Day. He attends church services in the Tombs, for Wells was a sensitive, very religious man. He was profoundly affected by the sermon. What would his thoughts be, do you think, under such circumstances? The services are over, he leaves, but this is the Tombs, you remember, he is returned to his cell. Would he be thinking of another tragic figure—of Othello, The Moor of Venice, who like him, might soliloquize thus as he slumps dejectedly in the corner:

*"O, Farewell—O now, forever,
Farewell the tranquil mind! Farewell content!
Farewell! Horace's character's gone!"*

He paces his cell, he stops, he sits down to write. He reviews the whole sordid matter. He pours out his heart to his dear wife—he can continue no longer—he writes—"his brain is on fire!"

*"O, that the Everlasting had not fixed
His cannon 'gainst self-slaughter! O GOD!
O GOD!*

*When he himself might his quietus make
With a bare bodkin?"*

The shadows lengthen—eerie forms take shape before his eyes, now dimmed with tears. "What forms are these, proceeding from the heat oppressed brain?" Could they be those Goddess' of Fate, silhouetted against the darkened wall? Clotho

RHODE ISLAND MEDICAL JOURNAL

and her sisters, Lachesis and Atropos who have done with their spinning of his thread of life. Yes, yes, the hour has come. Atropos, stands, shears in hand, poised for the fateful act.

He reflects—does he have the thought of Macbeth—"If it were done when 'tis done, then 'twere well, it be done quickly."

It is now quiet. It is finished; it is consummated—his river of time has passed into the Ocean of Eternity. The ghastly deed is not discovered until the dawn of Monday.

Monday, January 24th

The routine report—"Body discovered by guard."

Dr. Walters, the coroner, was called to hold an inquest, and the Jury rendered a verdict, "that the deceased came to his death by suicide, by inflicting a wound in the left thigh with a razor, while laboring under an aberration of mind."

While he had few honors during his lifetime, the numerous distinctions awarded him, posthumously, in recognition of his achievements, would require much time to enumerate. Honors were conferred upon him by France, just two weeks previous to his death—but, unknown to him. Monuments have been erected to his memory, here and abroad. And Wells' benefaction to humanity lives on.

In the words of Charles Noel Flagg who in 1899 painted a life-sized portrait of him, which hangs in the lobby of the Wadsworth Atheneum in Hartford, Connecticut wrote—"Horace Wells was one of the most unfortunate and one of the greatest men who ever lived." "The man who was able through his genius, to prove his life for mankind by the greatest gift ever bestowed by a human being upon his fellows."

At the convocation of the American College of Dentists held in Milwaukee, Wisconsin, in 1939, the Mace of the College was unveiled, and the seven "Immortals of Dentistry" whose names are placed thereon, were saluted. Among whom was

*"Horace Wells 1815-1848 — Scientist,
Discoverer of surgical anesthesia by
Nitrous Oxide."*

Such is a brief sketch of some of the life and accomplishments, triumphs and tragedies of Horace Wells, Dentist, Benefactor of Mankind.

*"On the tree of life eternal
Man, let all thy hopes be staid,
Which alone forever vernal
Bears a leaf that shall not fade."*

- in -

Elysian lands.

REFERENCES

- Chronological History of Horace Wells, W. Harry Archer, December 1939.
Life and Letters of Horace Wells (Jour. Am. Coll. Dentists), W. Harry Archer, June 1944.



REPORTS FROM OVERSEAS

(The heroic services of the Doctors on the fighting fronts forms one of the brightest chapters of achievement in the present war. We are pleased this month to call on our doctor-correspondents from Rhode Island to report to our membership from overseas fighting fronts. — The Editors.)

* * *

From "somewhere in Germany" *Captain Donald L. DeNyse*, of Cranston, informs us that he is completing 28 months overseas this month. He was in the Normandy invasion, making the landing from an LST on D-day plus 2, and since that time he has been in continuous combat duty with the field service, treating casualties or medically ill soldiers. He was in the battle for Brest, and now goes on our records as our first member to report to us from inside the Nazi frontiers . . . From a hospital a few miles outside of Paris *Major Kenneth G. Burton* reports that he is busy doing orthopedic work. Just before and for a couple of months after D-day, he was in service on the orthopedic section of a field hospital in England treating casualties from the channel, the beachheads and later the Continent. For two months he was chief of the orthopedic section of a general hospital and then, in October, he made the crossing to France. *Major Burton* reports that *Captain Parker Mills*, of Providence, is also in his outfit, but presently on detached service with the 7th Army . . . We are pleased to report that *Major Burton* writes that he is "always so happy to receive the R. I. MEDICAL JOURNAL, and it has followed me quite regularly considering my many moves" . . . We have heard that *Captain Himon Miller* is in Belgium but we have yet to get word from him . . . *Major Peter C. H. Erinakes*, of West Warwick, rounding out four years of service, reports the biggest job of his

Division as the co-ordination of the medical evacuation of casualties. He reports that his group is able to get patients from the front lines back to the evacuation and field hospitals in one and a half to two hours on the average by using jeeps modified with litter holders . . . *Lieut. Harry E. Darrah* reports he has been extremely busy serving exclusively as anesthetist of one of the larger general hospitals in the United Kingdom, and he lists two other Rhode Islanders in his outfit, a *Lt. Sarah McKenney*, a RIH nurse, and a *Hilda Richards*, a Red Cross worker who formerly worked at the State House . . . Continued service as a flight surgeon or else the influence of *A. J. Cronin* has prompted *Captain Richard S. Arlen* to write a book titled "You've Had It, Chump," all about an army doctor's reaction to a world gone mad.

HOME FROM THE WARS

We had a pre-Christmas visit from *Comdr. Frank B. Littlefield*, now stationed in Newport. If you know the Commander you will readily understand that our interview as far as finding out about his activities was pretty much one-sided. Non-committal as ever, he did finally admit that he had been in the front row for the Sicily, Salerno and Normandy tussles and of the three the Salerno was the worst . . . Also back from the European theater and stationed at Newport is *Comdr. Robert R. Baldrige* who had charge of the urologic service until D-day when "we all pitched in and treated every conceivable type of wound, disease and injury" . . . *Major J. Merrill Gibson* is back in Providence from India, and the Providence Journal carried an interesting report of his activities recently . . . We have heard that *Captain James T. Fallon* has returned from England, but to date we have not been able to confirm his present assignment. . .

continued on page 43

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continued from page 41

FROM THE EUROPEAN TO THE PACIFIC WAR

Captain George M. Vaznaian of Woonsocket is able to report on the war on both major fronts. He was on the African invasion, later saw service at Bizerte, Tunisia, and then spent three months at Colonel Guy Wells' hospital in Naples, Italy where the Anzio beachhead casualties were treated. After this came a return to the States with wounded men from the Italian campaign, after which came the assignment to the Pacific theater of operations where he is now doing general medical work at a hospital in New Caledonia . . . Major Laurence A. Mori reports from "somewhere in the southwest Pacific" that he is receiving the R. I. MEDICAL JOURNAL "as regularly as conditions permit" . . .

Lt. Col. James B. Moran, overseas two years with an infantry division, states he took part in the Guadalcanal, New Georgia and New Guinea campaigns, and he anticipated further action in the coming months. He reports that he has been with the same group during four years of Army service and they still have quite a few Rhode Island enlisted men in the battalion who came into service with the old H Company from Providence. A siege of malaria about a year ago has been his only setback . . . Lt. William H. Tully, of the Navy, informs us that his JOURNALS have not caught up with him the past few months, so we are sending a new supply that he may know of all the doings on these Plantations and elsewhere. After six months on a destroyer, Lt. Tully was detached and ordered to duty with a Construction Battalion at Bougainville. Four months there was followed by assignment to his present post at the construction depot at New Caledonia. He reports that Lt. Comdr. James P. Londergan of Providence visited the base recently and a dinner party ensued during which "we swapped quite a bit of news and spent three or four enjoyable hours talking over everything."

CALLING THE C B I THEATER OF OPERATIONS

Captain Richard D. Femino is our latest addition to the China-Burma-India theater. He is now reported as somewhere along the Ledo Road in Assam and he is battalion surgeon in charge of the medical detachment. He reports he is enjoying his work and is "seeing some tropical medicine first hand". He has met most of the members of the R. I. Hospital Unit, and also met Captain William McIntyre who is a member of one of the portable surgical units up forward. Captain Femino reiterates the pleasant news—to us—that so many men have sent back when he writes "have been receiving the R. I. MEDICAL JOURNAL and look for-

continued on page 57

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BOOK REVIEW

PROTEINS AND AMINO ACIDS. PHYSIOLOGY, PATHOLOGY AND THERAPEUTICS. Arlington Chemical Co., 1944. 189 pages.

This monograph was written by the Scientific Staff of the Arlington Chemical Company to be of value to the busy clinician, as expressed in the preface. As a comprehensive review of recent knowledge and advances in protein metabolism it can well fulfil its purpose. Fortunately it is not an advertisement for their product, Aminoids, and great care has been taken to evaluate recent publications in the field.

The book is divided into four main parts: 1. Normal protein metabolism. 2. Altered protein metabolism. 3. Clinical conditions associated with protein depletion. 4. Correction of protein depletion.

Each part is further subdivided into as many as twelve sections, each with a bibliography of original references.

In general, an unbiased attitude is maintained. Controversial subjects like urea formation are presented from both sides, and conclusions are based on evidence or not drawn. Chart 4, on page 137, which incidentally is the only place where Aminoids are mentioned, and the preceding text would seem to indicate that oral hydrolysed protein is effective in raising plasma protein in burns, yet

the all-important factor of a protein-rich diet is played down. If protein replacement in the tissues is 30 times that in the plasma, then 30 grams of hydrolysed protein per day could only replace 1 gram of plasma protein per day. This is a very small part of the indicated gain of 150 grams of plasma protein in 11 days. Whether oral supplement of hydrolysed protein is more efficacious in raising plasma proteins than an equal amount of protein supplement is still open to question.

The clinical evaluation of protein depletion by history, weight change, and appearance, and the cautions about interpretation of plasma protein values in the presence of dehydration, shock or trauma are timely and of much value to clinicians.

Numerous tables and charts of useful information are included that can only be obtained by search of several sources. The bibliographies are a guide to further reading for those who would like to have more detail.

In these days of war restrictions, protein is a scarce article to be enjoyed when flavored with sodium chloride. A pinch of the latter might be suggested with the monograph's treatment of oral protein hydrolysates, but the rest of it is up-to-date, thorough, and a valuable review of a neglected phase of metabolism.

RUSSEL O. BOWMAN, PH.D.

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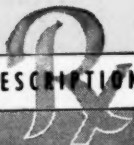
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DISTRICT SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The November meeting was held in the Nurses' Auditorium of the Memorial Hospital, Thursday, November 16, 1944. After a short business meeting the Association viewed an interesting educational motion picture on the treatment of cerebral injuries which had been secured by Dr. Laurence Senseman, treasurer. Dr. Wilfred Pickles of Providence commented on the methods of treatment shown and described other methods in current use.

MARY-ELAINE J. ROHR, M.D.

PROVIDENCE MEDICAL ASSOCIATION

A meeting of the Providence Medical Association was held at the Medical Library on Monday, December 4, 1944. The meeting was called to order by the President, Albert H. Jackvony, at 8:35 P. M.

The President reported that in view of the fact that the minutes of the Association would be published in the RHODE ISLAND MEDICAL JOURNAL they would not be read unless there was a request for the reading.

The Secretary reported receipt of a communication extending invitation to the members of the Association to attend the joint meeting of the Biology Seminar and the Rhode Island Section of the American Chemical Society to be held at Brown University on December 15, at which Dr. King of the Nutrition Foundation spoke on the topic, "Progress and Problems in the Science of Nutrition".

The Secretary reported that simplified application forms for the purchase of war bonds in connection with the 6th War Loan were available to the members.

The President reported that tributes prepared by Drs. Halsey DeWolf and Joseph C. O'Connell to the late Dr. George A. Matteson; by Drs. Charles Cooke and John B. Ferguson to the late Dr. Albert A. Barrows; and by Drs. John E. Donley and James Hamilton to the late Dr. Jerome J. McCaffrey have been filed with the Secretary.

The President called attention to the presence at the meeting of Capt. Clarence Riley, MC, a member of the Association home on furlough after 18 months in Iceland and he paid him tribute for his deep interest in the activities of the Association

as evidenced by his taking time during his brief furlough to attend the meeting. He also called to the attention of the members the fact that Dr. Riley is the only member of the Association, to his knowledge, who has been awarded a medal for meritorious service during World War II. This announcement merited a spontaneous round of applause from the membership in attendance.

Dr. Jackvony introduced Dr. Peter Pineo Chase who presented a case report concerning a very definite and extensively pathological chronic appendix. He expressed some skepticism as to the frequency with which real chronic appendicitis is found. On the other side of the picture, he presented this case. The appendix was very large, its walls were a centimeter or more thick in places. The thickening and induration extended well up onto the cecum so that excision of a portion of the head of the cecum, the appendix and terminal ileum had to be done. A very good colored slide of the specimen was shown.

The President introduced Dr. U. E. Zambarano, Superintendent of the State Sanatorium, and Dr. Richard Overholt, of Boston, attending thoracic surgeon at R. I. State Sanatorium, who spoke on the medical and surgical aspects of Bronchiectasis.

Dr. Zambarano stated that about 2% of the patients admitted to the State Sanatorium with respiratory diseases had bronchiectasis. He classified bronchiectasis as occurring in cylindrical, sacular and mixed forms. The dilatation of the bronchi and bronchialasis due to destruction of the muscle and elastic layers. The various causes were discussed insofar as they are understood. The onset of the disease often goes back to childhood. 50% of the patients have hemoptysis at one time or another. Ordinary physical examination may show very little even in severe cases. Medical treatment is only palliative. The prognosis in untreated cases is definitely poor. 25% to 40% die of complications of the bronchiectasis.

Dr. Cotton, associate of Dr. Overholt, made some preliminary remarks; especially, he outlined in detail a method of lipiodol injection which can be done in the office and requires only about 10cc. in order to adequately map the whole bronchial tree. Mention was made of the fact that individuals who have situs inversus are very prone indeed to have bronchiectasis.

continued on page 57

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"FIGHT INFANTILE PARALYSIS - JANUARY 14th-21st"

HOSPITAL ASSOCIATION OF RHODE ISLAND

LEROY P. COX, President**FRANCIS C. HOUGHTON, Secretary****HELEN M. BLAISDELL, R.N., Vice President** **WILLIAM SLEIGHT, Treasurer****ARTHUR H. RUGGLES, M.D., Editor**

NOTES ON ANNUAL MEETING

Hospital Association of Rhode Island

AT its Annual Meeting held on December 14th at the Pawtucket Memorial Hospital, this Association elected the following officers for the year 1945:

President, LEROY P. COX, Woonsocket Hospital
Vice-President, HELEN M. BLAISDELL, R. N.,

Westerly

Secretary, FRANCIS C. HOUGHTON, Butler Hospital
Treasurer, WILLIAM P. SLEIGHT, Memorial Hosp.
Trustees,

WILLIAM P. SLEIGHT, '45-6-7

FRANCIS C. HOUGHTON, '45-6-7

* * *

The matter of uniform accounting was discussed at considerable length. The American Hospital Association has been urging the adoption of such a system for several years. It was decided that the Superintendents of the various member hospitals in Rhode Island be urged to adopt the Uniform Accounting System and to keep it on accrual basis.

* * *

The Hospital Association of Rhode Island is extremely interested in the subject of Post War Planning and Construction. It feels that in order to consider this subject intelligently, we must have an "over-all" picture of present facilities and future needs. Action was taken to arrange for a state wide survey, designed to provide this information. This Section will contain more details about the survey as they are available.

* * *

The Hospital Association of Rhode Island, in cooperation with the Pawtucket Chamber of Commerce, has sponsored a series of radio broadcasts or skits. The material presented was prepared by the United States Chamber of Commerce and approved by the American Hospital Association. It was designed to more fully acquaint the public with the service which its hospitals are prepared to supply.

* * *

It is a pleasure to announce that the six months trial period for this section of the MEDICAL

JOURNAL has ended and that it has been considered successful from all viewpoints. It will be continued and it is the hope of those interested, that its value may increase materially with the passing months.

CLINICAL INFORMATION IN BOSTON

The Massachusetts Medical Society has established a Bureau of Clinical Information at its headquarters, 8 Fenway, Boston, Massachusetts, as a means of augmenting its postgraduate educational effort.

This Bureau will supply information as to the daily activities of the approved hospitals in Boston and its immediate vicinity.

This information will deal with each hospital's schedules of operations for the day, medical and surgical ward rounds, clinics, the location of such clinics and the names of those presiding over these various activities.

From time to time the Bureau will make available a bulletin which will list the fixed medical meetings and conferences held in the metropolitan area. This bulletin will be sent to Hospitals, Medical Schools, and Physicians on request, and will be available at the Bureau. In brief, its ultimate aim will be to serve the profession as a clearing house for all sorts of medical information.

The Bureau will be open from 7:00 a. m. to 10:00 a. m. and from 3:00 p. m. to 8:00 p. m. except Saturday afternoons. Information will be given by telephone.

No expense is involved on the part of those using this service.

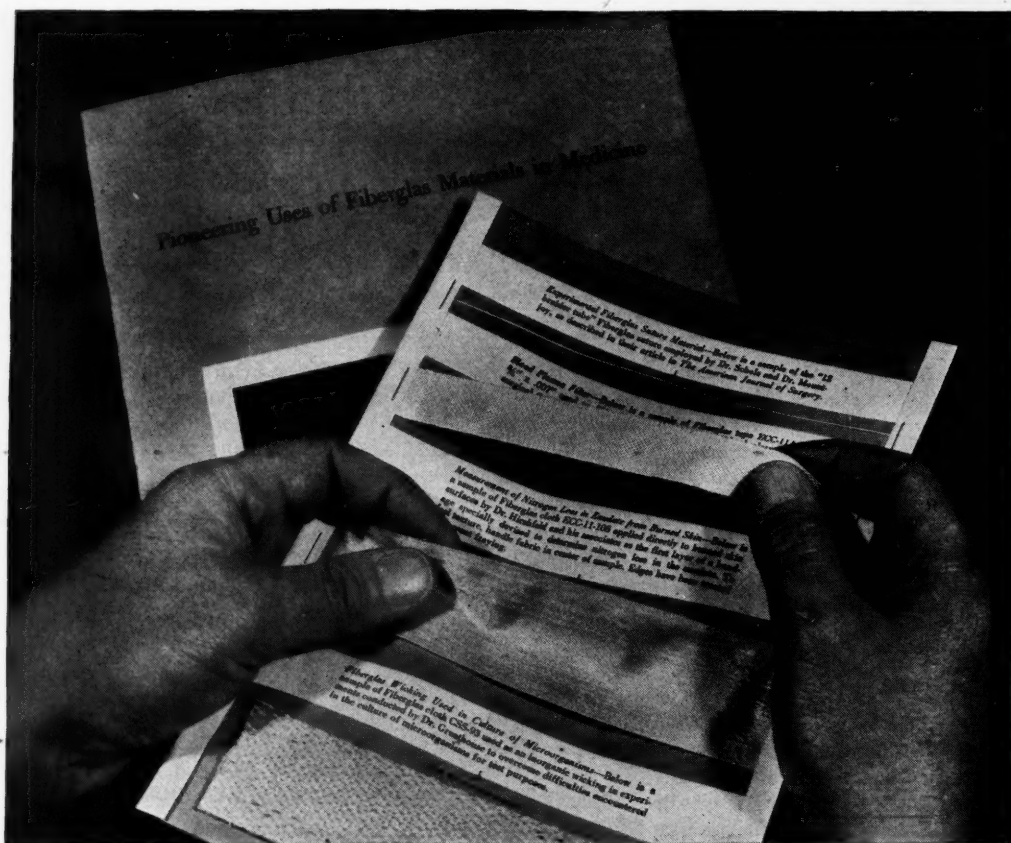
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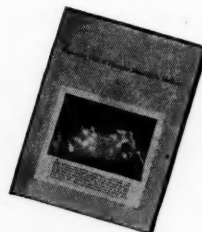
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INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH

Charles L. Farrell, M.D., *Chairman*; Stanley Davies, M.D.; Arthur E. Martin, M.D., Elihu S. Wing, M.D., William P. Buffum, M.D.

SEMINAR IN INDUSTRIAL HEALTH

THE Rhode Island Society of Industrial Physicians and Surgeons, in conjunction with the Industrial Health Committee of the Rhode Island Medical Society, is arranging for a postgraduate seminar in industrial health to be held at Brown University under the auspices of the new department of Medical Sciences.

It is proposed to have a series of eight lectures during the months of February and March to coincide with the second semester at Brown University. The lectures will, in all probability, be held weekly, on Tuesday evening at 8:30 p. m., and they will cover a variety of subjects that should prove interesting and instructive to physicians, nurses, industrialists and others in the field of health and safety in industry. The course will be general in scope and it should prove one of the most progressive and constructive steps taken in the country in stimulating a better understanding of medical and health problems in industrial work.

In planning the program no attempt is sought to teach industrial medicine per se, but rather the purpose will be to acquaint industry with what medicine has to offer, and also to inform doctors of medicine and nurses what constitutes good medical and nursing practice, within ethical limits, in industry.

The faculty for the program will be drawn from the foremost men in the field of industrial health. Dr. C. O. Sappington, editor of the monthly journal "Industrial Medicine", and author of several text books on the subject, is scheduled to lecture. Likewise, Dr. C. M. Peterson, secretary of the Council on Industrial Health of the American Medical Association, has accepted an invitation to talk on "The Basis of Medicine in Industry."

Among others on the faculty are Dr. John J. Wittmer on the Consolidated Edison Company; Dr. Harvey Bartle of the Pennsylvania Railroad, who will talk on "Physical Examinations"; and J. J. Bloomfield of the industrial hygiene division of the United States Public Health Service who will discuss labor management problems.

A tremendous amount of work and planning has gone into the preparation of this course and it is confidently expected that all physicians who have

WAR JOBS

Members of the Committee on Industrial Health of the Rhode Island Medical Society have met with officials of the War Manpower Commission in order to review and make recommendations for the purpose of tightening up on the issuance of medical certificates to workers seeking a change of jobs.

In view of the critical situation in Rhode Island at present all physicians are urged to review carefully each individual case before issuing a medical certificate allowing a worker to change from one position to another.

In the future the War Manpower Commission officials will scrutinize each certificate before releasing a worker on the basis of physical condition caused by his job.

In order to aid the War Manpower Commission in the urgent new program, physicians are urged to carefully review all patients' requests during the next sixty days.

any contact with industry, or who treat accidental injuries, will make plans to attend. Occupational diseases are receiving more and more attention from labor leaders as well as industrialists, and it is essential that the medical profession be fully informed as to the newer processes and hazards resulting from the use of new chemicals, plastics, etc. Coverage of these subjects is also planned during the course.

Complete details, including application blanks for enrolling in the course, will be mailed to every medical doctor in the State this month.

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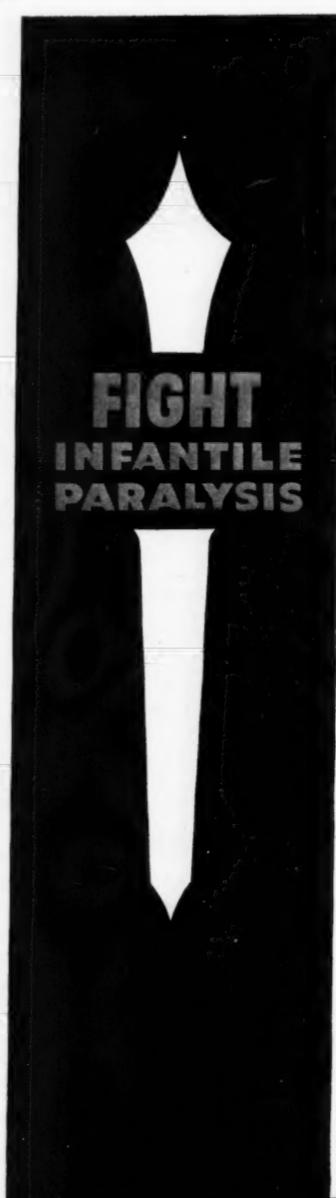
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The vast scope of the battle against infantile paralysis — involving the time, skill and knowledge of our finest doctors and scientists — cannot be comprehended by the majority of people. However, so deep is the desire of Americans to see the obliteration of this dread disease, that they have to date contributed millions of dollars through annual March of Dimes appeals for research purposes alone.

Recognizing the importance of the work of the National Foundation, Rexall Drug Stores proudly join with the American people in support of the 1945 March of Dimes, January 14—31.

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HOSPITALIZATION AND CASH SICKNESS COMPENSATION

Abstracts from the message to the Rhode Island General Assembly

by GOVERNOR J. HOWARD MCGRATH, on January 2, 1945

Hospitalization

IN the immediate past the subject of Public Health has remained foremost in my mind. The State is indebted to the Voluntary Advisory Council on Health for having devoted itself assiduously to the purpose of its creation. In addition to personal and individual research its sub-committee on Hospitalization has conferred on many days and for many hours in meetings throughout the year in a thorough examination of the intricate questions involved in a compulsory hospital program. It has sought to proceed with great caution. Its work is not yet complete, but I am advised we can look forward to its report early enough in the present session so that legislation can be introduced.

I refer you to my Annual Message of last year for the basic outline of those services that should be covered by a hospitalization program; also for the reasons that would seem to justify our State government in becoming a leader in the adoption of a social policy that would guarantee hospital care to the maximum number of citizens.

The Federal government is already constructing hospitals which will serve the members of the Armed Forces and give them hospital care under all circumstances. I understand this service is to be available whether or not the cause leading to hospitalizing was service-related. Many thousands of Rhode Islanders will be covered in this most important phase of social service.

We should not wish to see any segment of our population, because of inability to receive hospital care, contributing to weakening our physical standards of life when by organization within the existing economic order, and for so little cost, the health of the whole community could be improved through hospital care when needed.

I believe the Federal government's intent to provide general hospitalization for servicemen is one of the finest awards that a grateful people could provide for those who serve it so well. Likewise, I believe it sets a fine example to civilians to provide themselves with a system that will give all of us care approaching, if not comparable with, that provided by the national government.

The Technical Committee on Hospitalization has informed me that they agree that a plan of prepaid hospitalization is socially desirable; that with the co-operation of labor, industry, the medical pro-

fession and hospital trustees it can be provided through State sponsorship and direction within the framework of existing private agencies and without undue State control.

As stated on previous occasions, I now repeat that our policy as a State government with respect to this question should be established and written into law so that we may definitely indicate by action our desire that programs of social security be administered by the States; that we are willing to translate our desire into action which bespeaks an assumption of our responsibility to fulfill the need for such programs. The policy of the State being made known by legislative enactment, our hospitals will be in a position to estimate the demand that such a policy will place upon them in the future, thus allowing them to proceed with plans to meet this demand, confident that their investments in plant and facilities can and will be supported by those who make use of them.

It is obvious that no plan of universal prepaid hospitalization can be put into effect until we are sure that the services for which prepayment is made can be met by adequate facilities. So that any law that you would now be asked to approve would be for the purpose of encouraging the expansion of hospital facilities in Rhode Island. Payments toward a hospitalization plan would begin at a time and under conditions predetermined by you, and your approval to a law now would be primarily to encourage the expansion of hospital facilities in the State.

Cash Sickness

Rhode Island was the first and is still the only State that has enacted a Cash Sickness law. Our law and its operation has been studied by most of the other States whose representatives have come here from time to time, keenly interested to learn all they could about the operation of this program. I believe the present year will see similar enactments in other States. Naturally we are proud of Rhode Island's leadership and happy to know that others plan to follow our example. It is an indication that our concept of the soundness of Cash Sickness was right and is being accepted by others. Having no precedents upon which to work, it was inevitable that experience would develop opportunity for changes that would make it a better law and corrections that would remove defects that only the operation of the act would bring to light.

continued on next page

Due in part perhaps to the times in which we are living, the pressure of war work upon many who are not physically able to stand such pressure, the demands upon the Cash Sickness fund have mounted until we are now paying out benefits in excess of receipts. These causes are not solely responsible for this condition.

In the first instance, Cash Sickness Insurance was conceived to give some financial aid to a worker deprived of income because of illness, just as Workmen's Compensation was meant to give assistance to a worker injured in employment. When an injured worker is a beneficiary of both Workmen's Compensation and Cash Sickness, it is obvious that he receives more assistance than is available to the worker stricken by illness even though the illness, as is often the case, is brought on by employment-connected causes but causes that are not of an accidental nature.

Whether it is right or socially sound to allow a worker to be a beneficiary under both laws at the same time and for the same cause raises a very serious question. Certainly, if it is found that this policy constitutes one of the chief causes for the excess payments over income out of the Cash Sickness fund, it would seem that in fairness to all the workers the practise be stopped. The Cash Sickness law should provide assistance to workers who are out of employment because they are sick and because there are no other insurance systems that cover their case.

It would further seem to be against public policy for the State to adopt a series of Compulsory Insurance Laws in various fields all applicable to any one individual, through which, in the aggregate, by taking advantage of all of the laws, his income becomes greater in adversity than if he were able to remain at his work. This is so unless such insurance is to provide for specific payments for exceptional and extraordinary expenses that his adversity causes, in which case the payment should be made to the one furnishing the extraordinary service. The minority will find ways and means of taking advantage of such situations, but against that minority public policy must be exerted.

In the operation of the Cash Sickness fund the State becomes the trustee of large sums of money belonging to its workers. These funds need constant supervision and protection in the interest of the great majority who contribute to them. In addition, the benefits of the Act have to be administered.

The Unemployment Compensation Board, because of the nature of its work in the field of unemployment compensation, is a proper body to administer the benefits of our Cash Sickness law. I believe, however, that the fund itself and the policies affecting its investment and use should have the constant supervision of men experienced in finance.

In other words, with respect to this fund the State is in the position of an insurance company. You gentlemen know how many abuses would creep into the operations of an insurance company comparable in size to that which we are operating if it had to deal with a Board of Directors comprising one hundred forty-four members. That is about the situation the State of Rhode Island is in, for you gentlemen of the legislature, one hundred forty-four in number, are the Board of Directors for this fund.

There is very little that can be done to correct abuses, or to meet changing economic situations without your direct approval, which approval is available only during legislative sessions. Even then we must recognize that collectively we are not adequately experienced or specially trained in the intricacies of finance.

This leads me to suggest that this General Assembly, for the best interest of the fund and the fulfillment of the trust which it imposes on the State, for its wise investment and prudent expenditure should place wide discretionary fiscal powers in a Board of Directors chosen as you shall determine to administer the fund. Your law should establish the broad principles of operation. I think, by and large, you would be well advised to leave to the judgment of such a Board, broad details which by the very nature of things a legislative body cannot decide with speed and efficiency.

I am not at all convinced but that our Cash Sickness law can operate within the present contribution of one percent made by employees. However, men of experience in these affairs must determine how much by way of benefit can be paid for that one percent. There is no need of trying to do more than the figures will allow, and certainly nobody has any desire to do less.

I have not detailed all of the corrections that must be made in this law, such as a better definition of "sickness," a policy with respect to maternity benefits, increase of administration costs in the interest of greater efficiency. These matters will all come to you in the form of legislative bills to which I know you will give your early and serious attention.

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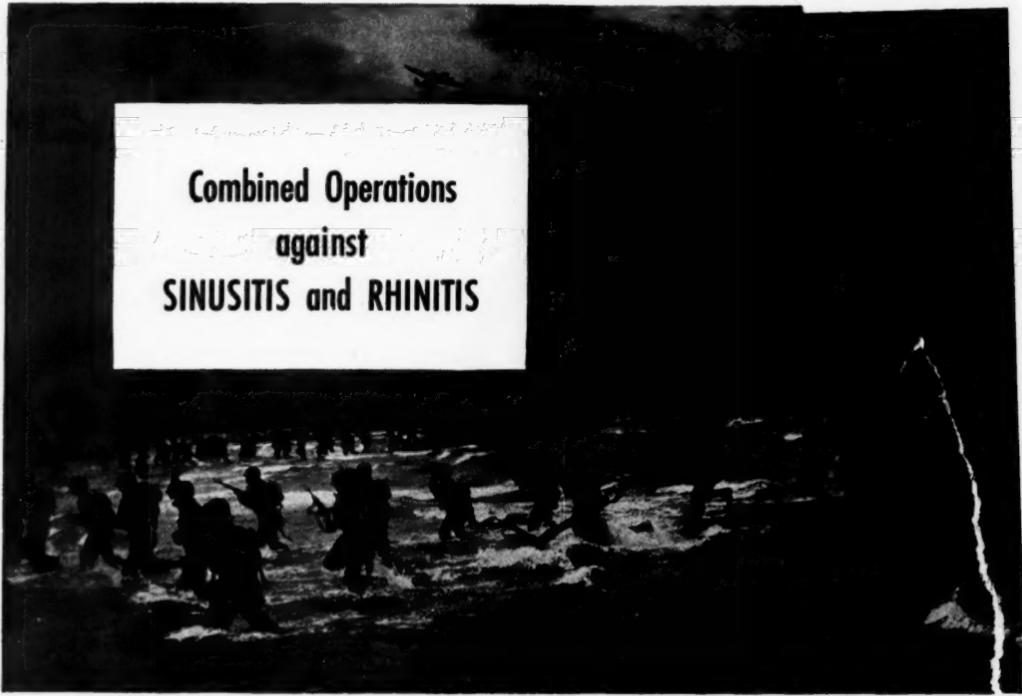
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DOCTORS AT WAR

continued from page 43

ward to each new issue, not only for its excellent articles but also to read the familiar names and events which keep me in touch with professional life back home" . . . It is now *Major John Dziob*, according to the latest report, for the promotion in ranks was made recently. He is now chief of surgical service with his group . . . A recent feature story in the *Providence Journal* related the experiences of *Major Eric Stone*, and we can augment that for our members with the information that the former R. I. Hospital Unit officer was detached from that group last September and given the job of organizing the first reconditioning and rehabilitation center of its kind to be set up by the Army. Doctor Stone writes us that he feels the "Society has done a great job in keeping in touch with its far flung members. And you can be sure they appreciate the interest and the difficult problems and fine work of their colleagues at home" . . . From somewhere along the Ledo Road in North Burma we have a message from *Captain Irving Beck* of the Evacuation Unit who states he is on the Chinese section of the Medical Service, treating a variety of diseases, mostly tropical. He reports that the "Chinese afford opportunity to see advanced and severe disease states not encountered to the same degree among our American patients."

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DISTRICT SOCIETY MEETINGS

continued from page 47

Three patients were presented who had undergone lobectomy by Dr. Overholt. One of the patients, a 19 year old married woman later asked permission to address the doctors and made some very striking and interesting statements. She particularly commented upon the fact that several doctors had discouraged her from having the operation which she later underwent and which has cured her chronic condition. One doctor told her that she would die of the bronchiectasis anyway so she might as well die of the operation.

Dr. Overholt stated that during the years 1888 to 1914 lobectomy or pneumonectomy was accompanied by an operative mortality of 50%. A series of about 212 cases after 1914 presented an operative mortality of 34%. Dr. Overholt reported on 202 cases of surgical excision of lung tissue which he has done. Lobectomies constituted the major portion of these operations, and the mortality was 1.2%. Of 18 pneumonectomies, the mortality was 11%. This represents two fatalities, one of them was due, several years ago, to a kidney shutdown following sulfanilamide therapy.

It appears definitely that surgery for bronchiectasis has become well established as a life-saving measure which presents a very small operative mortality. Instead of being considered a radical procedure, it should be considered a rational and conservative method of treatment since the mortality is so much lower than that attending medical treatment of the condition.

Dr. Overholt presented diagrams of his method of draining empyema which is done always by removing part of the eleventh rib. The rationale of this procedure was illustrated by the diagrams. The interesting papers were discussed and questions asked by Drs. McCurdy, Corsello, Ham, Windberg and MacCardell.

The meeting adjourned at 10:40 P. M.

Collation was served.

Attendance 98.

FRANK W. DIMMITT, M.D., *Secretary**Medical Secretaries . . .*

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MEDICAL LIBRARY NOTES

COMMITTEE ON THE LIBRARY

Herbert C. Partridge, M.D., Adolph W. Eckstein, M.D., Louis E. Burns, M.D.

NEW BOOKS AT THE LIBRARY

The Librarian announces the addition of the following books:

CANCER

Cancer. A Manual for Physicians. Published jointly by Michigan State Medical Society and Michigan Department of Health. 1944.

CATALOGUES

Index-Catalogue of the Library of the Surgeon General's Office. 4th ser. Vol. VIII, Wash., 1943.

DICTIONARIES

W. A. Newman Dorland — The American Illustrated Medical Dictionary. 20th ed. Phil., 1944.

ENDOCRINOLOGY

Jacob Hoffman — Female Endocrinology, including Sections on the Male. Phil., 1944.

GASTROENTEROLOGY

Henry L. Bockus — Gastro-enterology. Vol. II — The Small and Large Intestine and Peritoneum. Phil., 1944.

GYNECOLOGY

James V. Ricci — The Genealogy of Gynaecology. Phil., 1943.

HAND, surgery

Sterling Bunnell — Surgery of the Hand. Phil., 1944.

HEART

Paul D. White — Heart Disease. 3rd ed. N. Y., 1944.

HISTORY

John W. Haley — The "Old Stone Bank" History of Rhode Island, vol. IV. Prov., 1944.

INFECTIOUS DISEASES

Paul G. Kreider — The Bacteriology of Measles, Pneumonia, etc. Springfield, Ill., 1943.

MEDICINE

Henry A. Christian — Osler's Principles and Practice of Medicine. 15th ed., N. Y., 1944.
Modern Medicine Manual — 1943. Minneapolis, 1944.

NEUROPSYCHIATRY

Lowell S. Selling — Synopsis of Neuropsychiatry. St. L., 1944.

NUTRITION

Handbook of Nutrition. A Symposium Prepared Under the Auspices of the Council on Foods and Nutrition of the American Medical Association. Chic., 1943.

Proteins and Amino Acids. Physiology, Pathology and Therapeutics. N. Y., 1944.

OPHTHALMOLOGY, industrial

Hedwig S. Kuhn — Industrial Ophthalmology. St. L., 1944.

PHARMACOLOGY

New and Nonofficial Remedies, Containing Descriptions of the Articles Which Stand Accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Chic., 1944.
Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1943. Chic., 1944.

POLIOMYELITIS

Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis, 1943. Vol. IV. N. Y., 1944.

SURGERY

Thomas G. Orr — Operations of General Surgery. Phil., 1944.

TROPICAL MEDICINE

Otto Saphir — An Outline of Tropical Medicine. Chic., 1944.

Gifts to the Library

The Library has received special gifts of books and unbound journals from the following: — William P. Buffum, M.D., Peter P. Chase, M.D., Halsey DeWolf, M.D., Arthur E. Hertzler, M.D. Lucius C. Kingman, M.D., Miss Hope Vinton (from the estate of Frederick A. Vinton, M.D.)

A portrait of Doctor Albert Potter, President of the Rhode Island Medical Society 1888-89, has been given to the Society by Miss Ruth Boss of North Scituate.

RHODE ISLAND MEDICAL SOCIETY, NECROLOGY 1944

ALBERT ARMINGTON BARROWS, M.D. was born in Providence on October 13, 1877. He graduated from Brown University with the degree of Ph.B. in 1898 and received his medical degree from Harvard Medical School June 1902. He was admitted to fellowship in the Providence Medical Association and the Rhode Island Medical Society in 1904. Doctor Barrows died on October 9, 1944.

WILLIAM BRYANT CUTTS, M.D. was born in North Anson, Maine on February 3, 1869. He was a graduate of Bates College, receiving his A.B. in 1891 and his M.A. in 1894. He received his medical degree from the University of Pennsylvania School of Medicine June 15, 1899. Doctor Cutts was admitted to fellowship in the Providence Medical Association and the Rhode Island Medical Society in 1901. He died on May 24, 1944.

NATHANIEL HOWLAND GIFFORD, M.D. was born in New Bedford, Mass. on July 9, 1878. He graduated from Brown University in 1899 and received his medical degree from Harvard Medical School June 20, 1903. He was admitted to fellowship in the Providence Medical Association on April 6, 1908 and in the Rhode Island Medical Society in 1911. Doctor Gifford died on May 25, 1944.

HARRY JENNINGS KNAPP, M.D. was born in Norwich, Conn. on May 1, 1870. He attended the Norwich Free Academy and received his medical degree from the Long Island College of Medicine March 23, 1892. He was a member of the Newport County Medical Society and was admitted to fellowship in the Rhode Island Medical Society in 1902. Doctor Knapp died on December 17, 1944.

MICHAEL PETER MAHONEY, M.D. was born in 1868. He attended the Harvard Medical School where he received his M.D. in 1891. He was admitted to fellowship in the Rhode Island Medical Society in 1892. Doctor Mahoney died on January 21, 1944.

GEORGE ROBERT MANKIS, M.D. was born April 13, 1906 in Philadelphia. He received his B.S. from St. Joseph's College, Overbrook, Pa. and his M.D. from Hahnemann Medical College in June 1932. Doctor Mankis was admitted to fellowship in the Providence Medical Association on January 7, 1935 and joined the Rhode Island Medical Society on October 28, 1943. He died January 23, 1944.

GEORGE ARNOLD MATTESON, M.D. was born in 1875. He was a graduate of Brown University, in 1896, and of Harvard Medical School in 1900. He joined the Providence Medical Association

and the Rhode Island Medical Society in 1903 but gave up his active membership in September 1930. He has been a non-resident member of both societies since that time. Doctor Matteson died on September 30, 1944.

JEROME J. McCAFFREY, M.D. was born August 11, 1888 in Providence. He attended Holy Cross College, receiving his A.B. in 1911, and Harvard Medical College where he received his medical degree June 24, 1915. He was admitted to fellowship in the Providence Medical Association January 3, 1921 and in the Rhode Island Medical Society December 7, 1931. Dr. McCaffrey died on October 16, 1944.

GEORGE B. MCGRAW, M.D. was born in Kingsbury, N. Y., on October 11, 1867. He graduated from Union College in 1894 and received his medical degree from Albany Medical College April 17, 1894. He was a member of the Pawtucket Medical Association and became a fellow of the Rhode Island Medical Society on August 28, 1934. Doctor McGraw died on February 4, 1944.

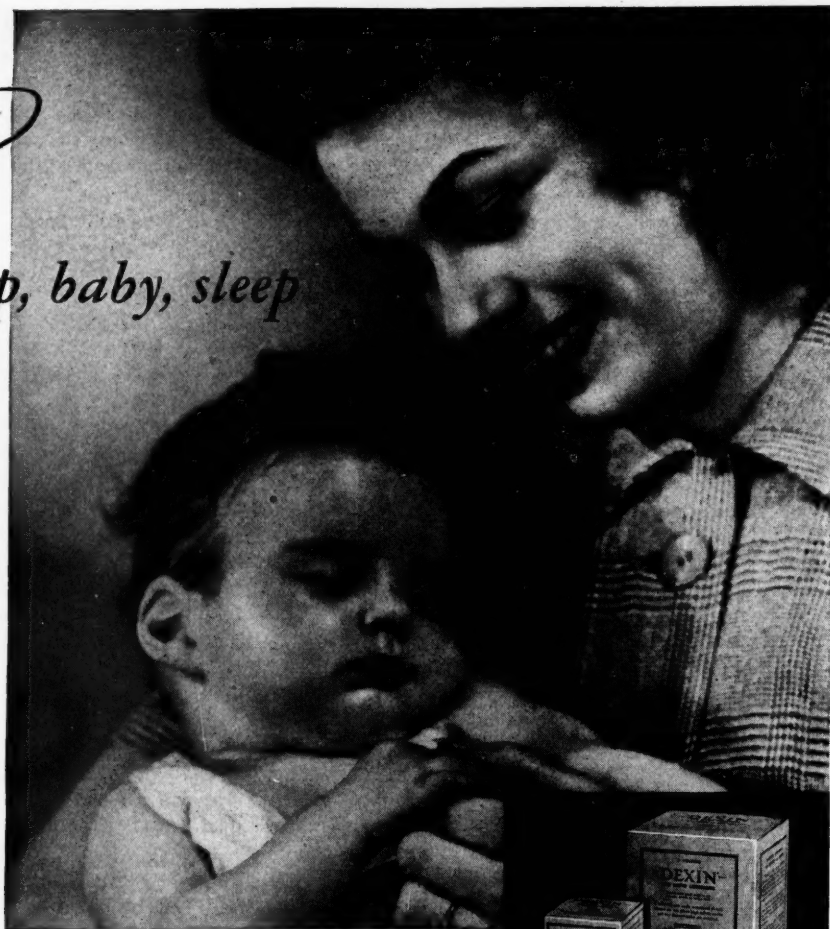
WILLIAM ROBERT MCGUIRK, M.D. was born April 29, 1871 in Fitchburg, Mass. He received his medical degree from Columbia University College of Physicians and Surgeons in 1892. He joined the Providence Medical Association March 7, 1910 and had been a fellow of the Rhode Island Medical Society since 1894. Doctor McGuirk died March 12, 1944.

ROBERT SIMMONS PHILLIPS, M.D. was born January 18, 1873 in Philadelphia. He received his Ph.B. degree from Brown University in 1896 and his M.D. degree from the New York Homeopathic Medical College May 24, 1900. He joined the Providence Medical Association December 1, 1941 and became a fellow of the Rhode Island Medical Society February 11, 1942. Doctor Phillips died October 23, 1944.

FLORIAN A. RUEST, M.D. was born in Rimouski, Quebec on May 20, 1869. He graduated from the College of Rimouski in 1892 and received his medical degree from Laval University Faculty of Medicine April 5, 1896. Doctor Ruest was a member of the Pawtucket Medical Association and was admitted to fellowship in the Rhode Island Medical Society November 1922. He died August 1944.

ROBERT MORTON SMITH, M.D. was born in Maitland, Nova Scotia on October 12, 1863. He received his medical degree from the College of Physicians and Surgeons of Baltimore March 13, 1889. Doctor Smith was a member of the Kent County Medical Society and was admitted to fellowship in the Rhode Island Medical Society in 1891. He died July 10, 1944.

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Literature on request



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½ oz. Ovaltine and 8 oz. of whole milk,* provide:

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IRON	11.94 mg.	COPPER5 mg.

*Based on average reported values for milk.

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—a high concentration (55 to 1) of the anti-secondary anemia principle.

Iron as Ferrous Sulfate

—the form considered to be most readily assimilated and utilized.

Vitamins B₁ • B₂ • Niacinamide

—deficiency of these vitamins often interferes with maximum absorption of RBC factors.

Vitamin C

—said to be "involved in normal erythropoiesis"; even mild deficiency may cause hypochromic anemia.

In pH 4.5

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important red cell essentials in a favorable environment.

VI-LITRON
for Secondary **ANEMIA**

DENTAL FILLINGS

The Army and Navy have set a theoretical ratio of one dentist to every 500 men. Actually, the American Dental Association reports, the ratio is about one to every 800 although more dentists are being recruited by the armed forces.

A soldier who cannot chew the Army ration is considered a casualty on the field of battle. He is as ineffective as a man who has been wounded. No soldier can be sent to an embarkation point until his teeth are in good condition.

The average American spends annually for dentistry only one tenth of what it would cost to put his mouth in good condition, according to a survey made by the American Dental Association.

For the first time in the history of the Army Dental Corps the rank of Major General has been bestowed on the Director of the Dental Division. He is Maj. Gen. Robert H. Mills, a veteran of World War I who has just returned from an extended tour of World War II theaters.

The Navy Dental Corps now has two Rear Admirals. They are Rear Ad. Alexander G. Lyle and Rear Ad. Cornelius H. Mack.

Canadian dentists are providing war wounded with false eyes made from the same materials used for denture bases, it is reported by the American Dental Association.

The Army has commissioned more than 13,000 dentists, while the Navy reports about 4,000 Naval dental officers.

The American Dental Association has received a formal request from the Chinese government for assistance in a public health program for China.

Dentists with the armed forces have manifold duties. Those stationed in clearing stations close to the front are prepared to give first aid in maxillo-facial treatment or routine dental service. At the actual front the dentist aids the Medical Corps and is prepared to perform any of the duties of an auxiliary medical officer.

Toothache is the result of diseased teeth caused largely by personal neglect. Through sound nutrition, daily oral hygiene and frequent inspection and care by the dentist, it is estimated that 75 per cent of all toothaches can be avoided.

Dentists on the home front are contributing thousands of man hours without charge, in examining selectees called by draft boards. They are giving priority appointments to war workers and youths about to be inducted into the armed forces.

NEW MEMBERS

The Secretary of the State Dental Society reports the election to membership of Dr. A. Beckman Carlson of 181 Vermont Avenue, Providence, and Dr. Mozart Maynard of 42 Curson Street, West Warwick.

Corsets for Dandies are a thing of the Past

Early 19th Century Fashion



But the years have added to Johnnie Walker's popularity

More in style than ever . . . that's good old Johnnie Walker. For a smoothness and mellowness that's unsurpassed . . . treat yourself to this choice scotch whisky.



Popular Johnnie Walker can't be everywhere all the time these days. If occasionally he is "out" when you call . . . call again.

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**BUY UNITED STATES
WAR BONDS AND STAMPS**



Post-Surgical Starvation

with its wastage of body tissues, especially tissue and plasma protein, "begins almost at once after protein is omitted from the diet." Hence it is recommended* that meat and other protein foods be added to the diet as soon as possible after surgery. Meat is not only rich in protein, but its protein is of highest quality, able to meet every protein need.

*"Surgeons are accustomed to attribute most of the postoperative weakness or asthenia to the operative procedure without realizing that much of it may actually be due to starvation, particularly deprivation of protein . . . the fall in plasma albumin begins with the very onset of a protein deficient diet . . . Solid food, as eggs and meat, should be added as soon as possible. Most postoperative patients can eat food much earlier than they are usually permitted to." Elman, R.: Acute Starvation Following Operation or Injury: With Special Reference to Caloric and Protein Needs, Ann. Surg. 120:350-361 (Sept.) 1944.



The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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Each Spencer Breast Support for pre-natal wear, like *all* Spencer Supports, is *individually designed* for the one patient who is to wear it, to lift and hold breasts in natural, healthful position, without compression.

It improves circulation—protects delicate inner tissues—helps prevent outer skin from stretching and breaking—aids breathing—improves appearance—encourages erect posture. Easily adjustable to increasing development.

Painful, engorged breasts are often relieved by a Spencer, as it allows veins to empty easily. (A further advantage is gained later in increased milk supply from equalization of circulation during pregnancy.)

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The Spencer Breast Support for nursing mothers provides protection against caking and abscessing. Closes in front for nursing convenience.

Spencer Sleeping Supports

are prescribed to continue day-time treatment during night hours. Protects breasts against crushing—aids breathing.

For service look in telephone book under Spencer corsetiere or write direct to us.

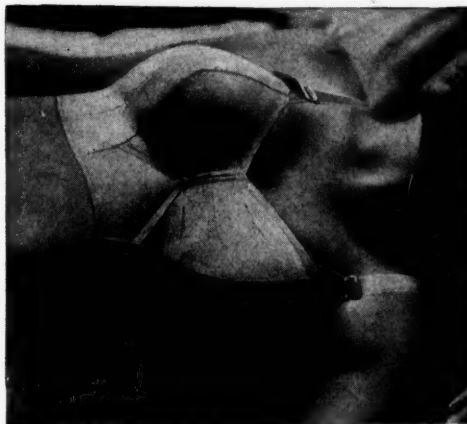
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FROM THE SECRETARY'S DESK

WILLIAM P. BUFFUM, M.D.

122 Waterman Street

Providence

SPECIAL MEETING OF DELEGATES

At the call of the President a special meeting of the House of Delegates was held at the Medical Library on Sunday, December 17, 1944. The purpose of the meeting was to hear the report of the Committee on Medical Economics regarding a possible plan for prepayment of surgical expenses.

The report was presented by Dr. Herman C. Pitts, chairman of the committee, and it was discussed in detail by the members present.

After the report had been accepted and placed on record, the House adopted a motion approving in principle of a prepayment voluntary surgical plan for Rhode Island.

The House also adopted a motion authorizing the formation of a Committee of eleven members for the study of a prepayment voluntary surgical benefit plan, as proposed by the Committee on Medical Economics. Six of the members are to be members of the Rhode Island Medical Society elected by the House of Delegates for terms of two, four and six years, and these elected members are to elect five non-medical members to serve with them for terms of three years each.

The House also moved that the Council of the Society submit at the next meeting of the House six members as nominees for this new Committee.

ELECTED BY COLLEGE OF SURGEONS

Official announcement has been made by the American College of Surgeons of the election of the following Rhode Islanders to Fellowship in 1944: Drs. G. Edward Crane, Edward V. Famiglietti, Lee G. Sannella, and Raymond H. Trott, all of Providence; and Dr. Orland F. Smith of Pawtucket.

SOCIETY OFFICER HONORED

The executive secretary of the Society was honored with a place on the program of outstanding national speakers who addressed the Ohio Chamber of Commerce at its 51st annual meeting in Cleveland on November 29. Sharing the platform with the Honorable Harry P. Jeffrey, Member of Congress from Dayton, for a forum on Social Security, Mr. Farrell spoke to the topic "Compulsory Disability Compensation". Other speakers before the convention included Colonel Frank Bane, executive director, Council of State Governments, Wil-

liam H. Davis, chairman, National War Labor Board, Thomas R. Jones, president, American Type Founders, Inc., of New Jersey, J. Frank Rushton, president Birmingham (Alabama) Chamber of Commerce, Carroll R. Daugherty, national director of wage stabilization, Arthur Motley, publisher of the American magazine, and Honorable John W. Bricker, Governor of Ohio.

DR. CORRIGAN ELECTED BY APHA

At the second wartime public health conference and 73rd annual meeting of the American Public Health Association Dr. Francis V. Corrigan, chief

continued on next page

MILITARY ANNOUNCEMENTS

CHANGE OF ADDRESS

LIEUT. ALFRED E. KING, Regional Hospital, Camp Swift, Texas.
CAPT. LINUS A. SHEEHAN, MC, Ward #1 C'D, Valley Forge General Hospital, Phoenixville, Penna.
LT. JACOB REICH, MC, #0-552324, APO 17366, c/o Postmaster, New York, N. Y.
CAPT. I. GERSHMAN, MC, #0-475735, APO 17407, c/o Postmaster, New York, N. Y.
LT. COMDR. ROBERT J. WILLIAMS, MC, USNR, U. S. Naval Hospital, Shoemaker, California.
MAJOR HENRY A. CAMPBELL, MC, 0443617, APO 17321, c/o Postmaster, New York, N. Y.
LT. JOHN T. BARRETT, MC, Medical Section, A.S.F.T.C., Camp Ellis, Illinois.
CAPT. HAROLD L. COLLOM, MC, 0235573, APO 17321, c/o Postmaster, New York, N. Y.
CAPT. PAUL COHEN, MC, 01696200, Med. Sec. #1, Regional Hospital, Camp Lee, Virginia.
LT. ROBERT W. RIEMER, MC, 0925892, Med. Tng C., ASF, Fort Lewis, Washington.
COL. GUY W. WELLS, MC, 0203017, APO 376, c/o Postmaster, New York, N. Y.
CAPT. STANLEY FREEDMAN, MC, Chief of Allergy Section, Crile General Hospital, Cleveland, Ohio.
LT. COMDR. WHITMAN MERRILL, MC, USNR, c/o Fleet Post Office, San Francisco, California.
LT. REGINALD A. ALLEN, MC, c/o Fleet Post Office, San Francisco, California.
LT. COL. JAMES B. MORAN, MC, 0-404363, APO 43, c/o Postmaster, San Francisco, California.
CAPT. GEORGE M. VAZNAIAN, MC, Embarkation APO, San Francisco, California.
CAPT. ROBERT W. DREW, MC, Med. Det., 722 M.P. Bn., Fort Du Pont, Delaware.
CAPT. IRVING BECK, MC, APO 218, c/o Postmaster, New York, N. Y.

PROMOTIONS

LT. ROBERT J. WILLIAMS to Lt. Comdr.
MAJOR JAMES B. MORAN to Lt. Col.
CAPT. NATHAN S. RAKATANSKY to Major.
CAPT. JOHN S. DZIOB to Major.

of the division of maternal and child health in the R. I. State Health Department, was elected as Vice-Chairman of the important section on Maternal and Child Health. The 1945 meeting of the Association will be held in Chicago the week of September 17, according to present plans.

SUCCESSFUL CANCER ASSEMBLY HELD

On November 28 and 29 a very successful regional assembly was held in Providence by the Field Army of the American Cancer Society. Lectures were given by the following members of the Society at the conference: Drs. G. Raymond Fox, Meyer Saklad, George W. Waterman, Peter Pineo Chase, and James H. Fagan. A dinner meeting was featured by addresses by Dr. Frank E. Adair of New York, president of the American Cancer Society, and Dr. Herman C. Pitts, chairman of the board of directors. The entire program was under the direction of Mrs. James C. Carmack, of Providence, Regional and State commander of the Field Army.

DENTAL SOCIETY GIES FUND

The Dr. William J. Gies Research and Endowment Fund was started in 1937 to promote research in dentistry.

It was named in honor of Dr. William J. Gies, Professor of Biochemistry at College of Physicians and Surgeons, Columbia University, who has long been greatly interested in the advancement of dental research.

The use of the fund includes grants to applicants in support of projected investigations, and also for the formal recognition through annual awards of distinguished achievement in dental research.

The endowment fund is in need of finances for further research, and no donation is too small. Today your Chairman has received donations from the following: The Rhode Island State Dental Society; the Pawtucket Dental Society; and Drs. Norman H. Fortier, Archie A. Albert, Philip J. Conley, Samuel Gorfine, Francis A. Holland, William A. Morinville, Albert A. Beausoliel, Joseph Romenski, Evans H. Nelson, T. Way McDonald, Ambrose Lynch, Maurice Denby, Albert L. Midgley, Ernest A. Charbonnell, Thomas W. Clune, Arthur Dring, Joseph Massicotte, Charles A. McKivergan, and James Krasnoff.

Your Committee invites further cooperation with this worthy project. Checks payable to the *William J. Gies Research Fund* should be forwarded to the Chairman, Dr. Archie A. Albert, 84 Broad Street, Pawtucket, R. I.

"Let us give a little back to that which made us what we are".

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IN

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Requires Analgesia
Bacteriostasis, and
Dehydration of the Tissues.

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How It Shortens
and Helps Avert

THESE drawings—from photographs presented as a scientific exhibit at the 1944 Meeting of the American Academy of Ophthalmology and Otolaryngology—demonstrate why Paredrine-Sulfathiazole Suspension is so strikingly effective in nasal and sinus infections. The choanae of patient T. D.—with subacute pansinusitis—are illustrated.

The dramatic success of Paredrine-Sulfathiazole Suspension in aborting colds and averting complications is largely due to its prolonged bacteriostatic action. When the Suspension is administered on retiring, for example, sulfathiazole can often be observed on infected mucosa the next morning—conclusive evidence that bacteriostasis has persisted all night long.

The fundamental reason for this prolonged bacteriostatic action is the fact that Paredrine-Sulfathiazole Suspension—not a solution, but *a suspension* of free sulfathiazole—covers the nasal mucosa with a fine, even frosting of sulfathiazole, which does not quickly wash away. Yet the Suspension does not cake or clump, and does not interfere with normal ciliary action.

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